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HEALTH CARE IN RURAL AMERICA: THE FRONTIER PERSPECTIVE

HEARING

BEFORE

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION
ON
COMPREHENSIVE HEALTH CARE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MISSOULA, MT

JUNE 28, 1989

PART 2

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HEALTH CARE IN RURAL AMERICA: THE FRONTIER PERSPECTIVE

WEDNESDAY, JUNE 28, 1989

THE PEPPER COMMISSION
U.S. BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE
Missoula, MT.

The Commission met, pursuant to notice, at 1 p.m., at 500 West Broadway, Missoula, MT, Hon. Max Baucus (Vice Chairman of the Commission), presiding.

Present: Senator Max Baucus.

Also Present: Edward F. Howard, general counsel; Steven C. Edelstein and Philip Shandler, professional staff.

OPENING STATEMENT OF CHAIRMAN MAX BAUCUS

Chairman BAUCUS. I know it's difficult for some to see, so I will try to compensate by speaking loudly, directly, succinctly, and I also encourage each of the witnesses this afternoon to do the same. We are laboring here under somewhat difficult conditions; it is somewhat difficult, I know, for those in the back part of the room, except for those standing, to see the witnesses and be directly involved, so let's all work together and cooperate to help adjust with that problem.

Today we are addressing, hopefully, the solutions to two major health care problems facing the United States. The first is the uninsured. That is those Americans who do not have health insurance, those Americans that slip between the cracks who do not have the health insurance protection that a lot of other Americans have. These people tend to be those who have part-time jobs, people who work for smaller organizations, smaller companies, people who are disabled, children, middle to lower income Americans. There are at least 37 million Americans who do not have health insurance. Certainly a tragedy for those individuals who do not have that health insurance. In addition, a very significant economic cost to hospitals, to institutions that try to, in a stopgap, quasi sort of way, make up the difference.

We are also here to address another major problem facing America, that is long-term health care and the inadequate system this country has in attempting to address long-term health care. We are a country with demographically more of an aging population. The long-term health care system, such as it is, does not begin to address most of the needs facing our Nation's elderly, that is home health care, respite care, adult day care, hospice care, to say noth-

ing of the cost of nursing home care. We have a system, unfortunately, today in America that tends to push our seniors into nursing homes; that does not allow people to stay in their homes where they'd much rather be. It's a system that forces Americans into poverty before Uncle Sam pays nursing home bills. It's very perverse, it's wrong, and it must be remedied and addressed.

We are also here today to be sure that any national solutions in providing for long-term health care and the uninsured, that is those people who do not have health insurance, is a solution that specifically addresses rural America, rural needs. We, in Montana, and in the Rocky Mountain States, have specific, different problems and needs compared with those folks who live in the big cities. When this country changed its ways of paying for acute care, that is hospital reimbursement and physician reimbursement under Medicare Part A, specifically, and also to some degree Part B, the Nation forgot about rural America. This country set up a hospital reimbursement system several years ago that hurt rural America. It is our hope here today in addressing long-term health care needs and solutions to long-term health care problems, addressing the uninsured and solutions to uncompensated care, that we do so in a way that addresses rural American needs.

The testimony that many of you today will give, the information that many of you will provide will go a long way toward helping this Commission fashion a solution that does not make some of the mistakes this country has made in other health care areas. That is the hope, that is the intent of our efforts here today.

This is one of several hearings of the Pepper Commission, the national Bipartisan Health Care Commission that Congress authorized about a year ago. I am one of the members of that Commission, I'm a vice chairman of that Commission, and as such I will undertake all the efforts I can to be sure that the solutions, as best as we can fashion them, are very much a rural solution that addresses rural Montana, addresses rural America. In addition to our State of Montana, there will be many other hearings across the country, about six or eight other hearings. This is one of those hearings and we are very fortunate that the Commission has one hearing here in our State.

Now, I think it's altogether fitting that we find solutions here in honor of Senator Claude Pepper. Senator Pepper is an American who dedicated his life passionately to serving people, and particularly our elderly, and I can think of no better memorial than a solution to the problems he was attempting to address. And so we here have an obligation certainly to ourselves, but also I think to Senator Pepper to dig down more deeply, think even more constructively to find solutions to these problems which would make him very, very happy.

I think the hearing today, too, should also be a memorial to a great Montanan, Earl Reilly. Earl Reilly, who was president of the Montana Senior Citizens Association, also dedicated himself to seniors' problems, to find solutions to seniors' problems. For both Senator Pepper and Earl Reilly, it is my hope and it is my belief that this will be a very successful hearing.

Now, a couple of housekeeping matters. There are a lot of folks here, fortunately, but like everything, there's compensation in that,

too. I know a lot of you would like to testify, a lot of you have something you want to say, and believe me, I and the Commission want to hear you. I will encourage the witnesses to, and myself included, to be succinct and direct and try to address some solutions and some ideas and to advance some testimony that's helpful so that at the end of the formal part of the hearing, any of you who wish to say something on a point any of you wishes to make shall do so, and then I'll open it up for anyone to speak his or her peace, say whatever he or she wants to say, beginning, I'm guessing, around maybe 3:30, 4 o'clock, about then. And I will stay here as long as I can and as long as you want to, but with the outside limit being, I think, about 6 o'clock, we all have to eat, so we'll have the formal hearing and then we'll open it up for questions after that and points of view after that.

Now, I'll also take a break at about 2:30 to 3 o'clock for 10 minutes. So if you're getting a little antsy about that time, rest assured we'll take a 10-minute break, and I'll try to keep it to 10 minutes. In addition, I'd like to introduce some folks here who are very, very important to this effort. First, some staff members of the Pepper Commission. To my left is Ed Howard. Why don't you raise your hand. Ed is the general counsel of the Pepper Commission. In addition, Steve Edelstein. Steve is over on the other side. Steve and Ed both have come all the way from Washington, DC, to join us. They're the staff members of the Pepper Commission, and, Steve and Ed, I know that you're going to very much enjoy your time here. Walk up to Steve and Ed afterward during the break and give them your ideas, too. That's why I'm introducing them, so you'll all know that they're here. I'd also like to introduce Phil Shandler. Phil is the media press person for the Pepper Commission. Feel free to talk to Phil. Also Heidi Werling. Come on, Heidi. Heidi is from Missoula. She is on my staff in my office in Washington, DC. Her area is health care, so be sure to talk to Heidi and so forth. And when you're calling Washington, DC, and you are not talking to me, you are probably talking to Heidi. Holly Luck—is Holly here? Holly has worked in our Helena office. Holly is very involved with senior citizen associations around the State. Feel free to talk to Holly, as well. And frankly, I'd also like to thank our stenographer, Fran Henderson. Fran has been working very hard and let's all help Fran by speaking not quite so quickly as we otherwise might.

[The prepared statement of Chairman Baucus follows:]

Statement of Sen. Max Baucus (D) Montana
Hearing of the Pepper Commission
Missoula, Montana - June 28, 1989

We're here today from all over Montana for a unique hearing. The Pepper Commission . . . of which I have the honor to be a vice chairman . . . is the first body created by Congress to develop summit-level solutions to the two major outstanding health problems facing America today. And this hearing is THE hearing . . . of eight or ten we plan to hold around the country to document the national problems . . . that is looking at health care availability and cost in a RURAL perspective.

The two national problems are these: 37 million Americans don't have health insurance . . . almost one out of five people. As a result, too often these folks don't get the health care they should. The other problem is the extraordinary cost of LONG-TERM care . . . for which there is almost NO insurance. A million folks a year go bankrupt trying to provide for their loved ones who need long-term care for essential acts of daily life. That care costs an average of $25,000 a year in an institution . . . almost $12,000 a year at home. We have a perverse long-term health-care system in this country: it encourages putting people into institutions for care. And it forces people to go broke before it provides any assistance in paying for the care of their loved ones. That's not right. We need to fix it.

And in RURAL states like Montana our people and our care-giving institutions have special problems. People have to go great distances for care. Sometimes they don't get it. And hospitals and other care-giving institutions are not adequately REIMBURSED for the care they provide. Their costs are higher because they have to have and maintain high-quality equipment and staff. . . to care for FEWER PEOPLE than big-city hospitals do.

The law that Congress passed to reimburse hospitals didn't take into account the especially high overhead costs of rural hospitals. We have to fix that law. And we on the Pepper Commission have to assure that it doesn't happen again. We must assure that the solutions we propose take into consideration the unique needs of hospitals and other institutions in states like Montana.

Today we are going to hear from individuals and families . . . institutions and experts . . . on the impact these problems have on them . . . and what they think should be done. This first-hand testimony . . . and the suggestions we hear . . . will help the Pepper Commission develop its solutions. All Americans are entitled to the health care they need . . . without going broke to get it. I will all I can, as vice chairman of the Pepper Commission, to get a SYSTEM into place that takes care of the health needs of all Americans . . . and pays proper attention to the special needs of states like Montana.

OK, let's get started. Our first witness is Dr. John Coombs, who is the vice president for medical affairs at the Multicare Medical Center and is chairman of the Subcommittee on Rural Health of the American Academy of Family Physicians in Tacoma, WA. Dr. Coombs, we're honored to have you here. Why don't you begin any way you think is appropriate.

STATEMENT OF DR. JOHN COOMBS, VICE PRESIDENT, MEDICAL AFFAIRS, TACOMA HOSPITAL, TACOMA, WA, AND CHAIRMAN, RURAL SUBCOMMITTEE, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. COOMBS. Thank you very much, Senator Baucus. I'd like to, first of all, say that if you can't hear me and you are having difficulty, raise a ruckus because that's the only way I can tell if I'm not being heard.

Chairman BAUCUS. Before you begin, raise your hands in the back if you are having a hard time hearing Dr. Coombs. Doctor, just pipe up, OK?

Dr. COOMBS. I'll boom it out. I very much appreciate the opportunity to address the Pepper Commission and present the views of the American Academy of Family Physicians. The American Academy of Family Physicians is a specialty organization comprised of approximately 66,000 members across the country; family physicians who are both in training as well as in practice. Of that number, approximately 30 percent practice in rural areas, and if you look at towns under 10,000, approximately 90 percent of the physicians practicing in those towns are, in fact, family physicians.

I'd like to address the Commission today speaking from the background of a career which initially was headed—my own career—toward academic gastroenterology. During the course of my training, I had the opportunity to visit Great Falls, MT, on a WAMI rotation. WAMI is a part of the University of Washington School of Medicine decentralized program for training students and residents, and that's where I really got the fervor to pursue a career in rural practice and specifically in family medicine.

As a National Health Service Corps volunteer in 1973, I was a part of the experiment. I was assigned to a town with a dying hospital, a town of 950 people. I was also joining two older general practitioners who were in practice. After approximately 6 to 9 months in practice, I was by myself in this town. The town also had a nursing home with 75 beds. That's how my career in rural health began and the transition of that community and developing that rural health care system became the basis of my background and forms the basis of a lot of the remarks that I'll make today.

I practiced for 10 years in that rural community in Okanogan County in north central Washington, my home State. To give you an idea of the rural geography, the school district, for instance, in the town of Tonasket is the size of the State of Rhode Island and children oftentimes would spend as long as 2½ to 3 hours on the bus every day to get in to school. In addition, our town had the only stoplight in the county, something that people used to come from miles around to take a look at and marvel at. My wife, who joined me in Okanogan County, we married in Okanogan County,

was a lifelong resident of that county. Her family arrived in the 1850's in the Biles Longmiere wagon train, and she has provided a great deal of the basis of my heritage in rural health, as well as rural life in general, for me and is a constant beacon.

I wanted to talk today about what family practice is and how it relates to rural practice, what is the relationship to rural health, and what are some of the challenges that I see in front of us so that we can provide an adequate supply of doctors to care for the populace in rural areas. Many of the details are written down in my written testimony, which I have submitted for the record, but I've chosen to make my verbal remarks in a more descriptive way and a more example-oriented way and a way where I can speak from the heart. I think there's no better way to characterize family practice than to talk about some of the characteristics that make up a family physician who practices in a rural area. They are people who have to be self-reliant, they have to have a great deal of self-confidence and self-assuredness. They have to be able to overcome oftentimes what are local prejudice toward health care, prejudice toward a hospital, which has always been viewed as a place where people go to die rather than a place that actually nurtures the health of the community. As an example of that, I can say that the self-reliance and self-confidence manifests itself in many ways. All the way from one night that I spent 6 hours in the emergency room taking care of six people who were seriously injured, two of whom died, in a serious car accident. This is one of the things that I think characterizes rural family practice. You don't only have to be self-assured, you have to be able to handle a wide breadth of problems in practice. Problems that stem all the way from caring for a close friend's wife who is dying of cancer and making sure that she can die with dignity in their home, or hand ventilating a baby by bag and mask providing artificial ventilation after the mother happened to drop in and have the baby in my hospital. And we had to hand bag that baby in 1974 for 7½ hours in the community ambulance to take them to a newborn intensive care unit. It was real gratifying when that baby came back to the prekindergarten screening program at age 5 that we had developed within our community with the assistance of the school system and started school in a normal fashion.

In addition, there are other examples that I think stem far and wide. There's never time to rest when you are in rural family practice. My partner, as an example, settled down for a Thanksgiving dinner 3 years ago and was suddenly aroused at the door when a neighbor's wife came over after the husband was hit in the neck with a chain saw while he was preparing wood for the fire. There was nothing he could do except comfort the family and prepare them for a life on a farm without the primary breadwinner being available.

There is another example of counseling an alcoholic patient whose son had just died of sudden infant death syndrome [SIDS]. These are examples which I think point out the breadth of family practice in rural areas and things for which we have to prepare future rural practitioners during residency. But it's not without humor. I can recall also the times when, as an example, I got called in the middle of the night to come right out to a house to

take care of Jamie, who was desperately ill. It turned out that Jamie was a 1½-old pony of one of my patients. Or sitting down in the local greasy spoon, the cafe in our hometown, next to the vet at 5 o'clock in the morning and discussing the caesarean sections that we had just respectively done. His obviously was on a bovine.

Patience is also required to be a family physician in a rural area in the face of adversity and in the face of the unknown. Working with individuals trying to find out what they want their health care to be like, setting priorities on the basis of what their individual priorities are, that takes patience and it takes time, awareness of our limitations. Knowing that the principles of primary care are, which stand always, when to get consultants, how to get consultants, but at the same time always meeting the wishes of the patient and the arrangement that you have developed with them. The perspective that we have to have as far as for the medical system in general or for the individual as an individual.

Something I really want to center in on today, the heart of the rural health, is innovation. It's the ability to work within the resources that you have within the community, the individuals who are there. The resources are frequently scarce, they are frequently small, and oftentimes we have to decide on the spot how we are going to organize those resources to make things happen. I'll talk about that in relationship to regulations later on. The one thing that I teach my residents now in our residency program, and I've gone now to teach rural health within a family practice program, is that each experience that you'll learn today, at some point in your rural career you'll be able to use that, the knowledge that you gained, and that's the way it is.

A sense of community is absolutely essential. Assuming a leadership role that oftentimes in a very unassuming way of organizing people within your town, within your community to use the resources that are at hand. It's being comfortable with living in a public life, of walking down the aisle in Safeway and being able to face your patients who you may have just seen with a sensitive matter and saying good morning. Sharing with them their joys, sharing with them their trials and not being inhibited about it.

It's taking all comers. You don't do a wallet biopsy when they walk in the door, but rather every patient who walks in the door, you take care of them, and that oftentimes is difficult because poverty is much higher in rural areas. As much as a third higher in rural areas compared to urban areas. The 24 percent of children under the age of 18 years live in poverty, below the Federal poverty level in rural areas; that 32 percent of agricultural workers are uninsured and that 49 percent of the agricultural population who do live in poverty are also uninsured, but we take all comers. That is what our mission is, that's what we have to do. Also, if you look at the elderly, even though 25 percent of the population live in rural areas, over a third of the elderly population in the United States live in rural areas, so there's a disproportionate number of elderly people and we have to provide for their care, as well.

I've touched on the breadth of the care, but also the clinical acumen of the family physician is absolutely unmatched and it really becomes a model for the kind of health care which we provide.

So rural family practice is really a model for primary care in the U.S. health system. We become patient advocates, we become cost-effective treatment providers, we become ethical care providers with the individual. We provide continuity of care and we provide a comprehensive set of care. All of those things, I think, is the way we like to reflect upon what a "country doc" used to be, and what I feel still are. Family practice is good for the country.

What are some of the challenges ahead so that we can preserve this? First, I might say that I think there's a sense of urgency, because if I look at the population of family physicians within this country, it's a bimodal distribution. We have a peak at about 42 years of age of new physicians who are coming into the new specialty of family practice established in 1969, but we also have a very large number, the average age of which now is about 61, which over the next 5 years will be entering into retirement. We have to replace those people, and we have to replace them with well-trained individuals. Many of those people practice in rural America. As I mentioned, rural family practice is the heart of physician care within rural America. To do this we need to do several things. First of all, it's my opinion that in our medical students and our undergraduates we have a strong sense of idealism and altruism that exists already. They have a strong missionary zeal and we need to do things to preserve that, to preserve their desire to help people, to preserve their goals, to make a difference in the lives of people, because it gets beaten out of them in medical school. How do we do that? Well, I'm a firm believer in the National Health Service Corps and it's circling the drain, it's disappearing. We need to replace that. We need to provide to medical schools support which is tied to the necessity of having a family practice rotation for those medical students, the necessity of offering them opportunity for rural health experiences. We also, through the so-called 786 primary grant cycle, need to establish priorities which say rural health is important within our residency programs. And we need to create centers of excellence for the education of future rural physicians; training opportunities for residents to learn what it's like to be a family physician in rural areas.

For practicing rural physicians we need to be able to take away and protect them from disincentives to stay in practice. This includes the tremendous horde of regulations which bias themselves toward rural areas because oftentimes they're built for urban and rural areas, working to the detriment of rural America. I'd be happy to give examples of that. We need to create a fair shake in terms of reimbursement for the third-party payers for physicians who choose to practice in rural areas, and very important, we need to support our rural hospitals. Not necessarily as they are today, but we need to preserve them as the centers of health care for the community, we need to give them the opportunity, in innovative ways, to diversify, to meet the needs as they exist today. As Senator Baucus says, the hospice, the home health, the various other things which are created within vertical integration of health care within a rural community.

In the area of obstetrics there's a tremendous crisis which exists, as oftentimes graphically pointed to, in this State of Montana, where over a third of the counties there is no obstetrical care avail-

able and people have to travel tremendous distances in order to receive care. That's tough. I know when I had my children in Tonasket, it was tough to travel the 16 miles that it took to go to the hospital. I don't know how my wife and I made it, and I can imagine that if you have to travel 30 or 150 miles to receive that care, that it has to be thwarted with a tremendous number of problems that can't help but influence the outcome. There's higher infant mortality in our rural areas. We need to address that. There is also, all over the country, long traveltimes that decrease the amount of access to care in obstetrics.

Why are physicians leaving obstetrical care? Because of the malpractice issues, because of the fear that is being created in terms of being sued by patients and by the system because of personal demands such as coverage, especially in light of increased technological demands, and because of the cost of providing that care. We need to address that, and I think there's some very good solutions that are in the offing.

We need to address the problems of the uninsured, and that's what we're here today to talk about; to improve their access to care. No longer is there anywhere to shift the cost of that care because of a variety of reasons, managed health care, cost containment within private insurance, et cetera. There's nowhere that we can cost shift the cost of taking care of those patients. We need to create incentives for people to care for those people, and I'm not talking about just money, I'm talking about incentives of caring for the poor, such as recognition to the people that are committed to providing care, that they are there committed to making a difference as far as the health care of their community. It's very difficult when my business manager or my clinic manager walks up to me and says: "John, you've got to cut down on the number of uninsured people you're seeing. We just can't make it, I can't pay the bills, we are just not going to be here." And I say: "We have to find a way."

Finally, the last two things I wanted to talk about are standards of care and innovation. The standard of care as it exists right now is being developed within all of our specialty organizations. There's a difference between the standard of care of health care delivery between rural and urban areas. There's only one standard of care which exists in the United States. I understand that, and everybody should have access to that, but the nature of rural practice, the geographic modifiers, the barriers that are created, can't help but influence how that care is provided. Ethically we are closer to our patients, we know what they want. That oftentimes doesn't fit a lock step standard of care, which is developed only to preserve health care in a very nonsensitive, impersonal way. We need to protect that right, we need to protect the right of our patients. We need to also understand that the nature of rural people is different from urban people. They're proud, they are self-sufficient, and oftentimes they have a tremendous fear of cities. I can recall one patient of mine who had a melanoma, which is skin cancer. The best thing for him was to get specialty care. I talked to Luke and we talked about his music and about the importance he had to the community. And finally he agreed to go to the doctor if I'd go with him. So one morning we got up real early, we traveled the 320

miles it took to get to the specialist, and we had quite a day. I tell you, I learned a tremendous amount that day. It's something where the standard of care is there, yes, but we have to preserve and we have to be sensitive to the needs of our patients first. We have to be careful about what the professional review organizations are doing as far as the review of myself and my colleagues as it relates to those standards of care. We have to protect their right to be innovative. We have to be careful about the medical/legal aspects of the way things are done, also. I read a torts book in a law class this year that I saw, and it said rural practice automatically attracts people who can't make it anywhere else, these are bad doctors, we need to get them out of practice. In fact, what I think is that these are people who are in touch with the kind of care that needs to be provided throughout this country.

In the area of innovation, we need to be able to nurture the kinds of activities that go on in rural areas which meet the need. As an example, in outreach surgery or itinerant surgery where surgeons and specialists from another community, an urban community, may visit occasionally a rural community to provide the care there for their patients in conjunction with their family physician. This creates access for geographic-bound patients, it sensitizes specialists to the needs of rural areas, it creates continuing medical education for family physicians in rural areas, and reduces the isolation. We have to ensure that this is done in a quality way, and this is an example where innovation may help everyone. And I just reviewed some of the transitional grant applications that are being made by rural hospitals, and outreach specialty care is something they want to see, as well. We also have to be able to protect, through innovation, alternative care, such as hospice care was mentioned. There is a regulation which says that there can't be offsite offices for hospice greater than 10 miles, as an example, from the central office. That directly affects hospice programs in rural areas. I can give other examples, but I won't do that at this time.

I appreciate the opportunity to share these verbal remarks and written testimony to the Commission on behalf of the Amercan Academy of Family Physicians. I hope that this has further sensitized the Commission to the unique nature of rural practice and rural health. I hope that the role that the specialty of family practice plays in providing that care in rural America is also perhaps more clear. I'm proud of the rural heritage and I'm also proud of the place that the rural country docs have played in building that, and I appreciate very much the opportunity to share with you my feelings. Thank you.

[The prepared statement of Dr. Coombs follows:]

STATEMENT of the American Academy of Family Physicians

BEFORE THE

BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

FIELD HEARING
IN
MISSOULA, MONTANA

CONCERNING RURAL HEALTH CARE

June 28, 1989

Presented by

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My name is John B. Coombs, M.D., and I am pleased to be able present the views of the the American Academy of Family Physicians at this hearing of the Bipartisan Commission on Comprehensive Health Care. The Academy is the national medical specialty organization representing over 66,000 practicing family physicians, residents in training, and medical students. On behalf of our members and their patients, it is a privilege to appear before the Commission to discuss issues related to access to health care in rural America.

In no other setting does the family physician play such a prominent role as in rural health care delivery. Indeed, the image of the rural family physician has a powerful influence on the way family physicians think about their role in society. It is not surprising that nearly 30 percent of family physicians live and practice in rural communities, a percentage almost twice that for the medical profession as a whole. And, almost half of graduating family practice residents are locating their practices in rural areas or in towns with populations of 25,000 or less. The Academy recently consolidated its broad activities related to rural health care into a Rural Health Task Force, on which I am privileged to sit.

There are many problems faced by rural Americans in obtaining access to health care, and the bulk of my testimony will attempt to define and propose solutions to these problems. But, before talking about rural

health problems, I wish to underscore the strengths of rural health care. It is important for the Commission to understand some of the reasons why rural health care may be better health care.

Rural health care is built solidly on a foundation of primary care. While the overall level of health care resources may by low, the mix of providers that are actually available in rural communities is generally appropriate to the health care needs of the community. Rural health care providers know and are known by their communities. Because of the nature of rural living, the assessment of health care needs is based on more than a rapid, onetime analysis of physiologic status. Rather, it is based on an ongoing knowledge of an individual's desires and on a knowledge of the individual's role in family and community.

Fifty-six percent of physicians in rural areas are family or general physicians, twice the proportion of these physicians in urban areas. The proportion of family and general physicians in small rural counties (population less than 10,000) is even higher, 91 percent. Entry into the rural health care system is, therefore, largely provided by physicians who specialize in care that is comprehensive, continuing, and both preventive and curative. According to the family practice model, understanding an individual's broad and varied health care needs requires an understanding of his or her role within family and community, and meeting an individual's needs often means working with family and community and, at other times, coordinating more technological health care services.

From the general paucity of resources in rural areas has grown the spirit of innovation and self-reliance that permeates all aspects of rural life. The demands placed on rural physicians require a breadth of knowledge and a degree of clinical acumen unmatched in any other setting. Under circumstances of scarcity, rural physicians must carefully weigh the utility of obtaining tests or ordering treatments of questionable necessity. Rural patients are less likely to be subjected to procedures ordered simply to remove the last bit of doubt, and have largely been spared the expense and risk of unnecessary tests and treatments that are overly abundant and aggressively marketed in urban communities.

Health care in rural America is built on a primary care model that emphasizes continuity and comprehensiveness and provides a mix of services that closely approximates the health care needs of society. As we move on to address the problems faced in obtaining and providing rural health care, it will be important to build on the strengths that already exist in the rural health care system.

The Challenges Facing Rural Health Care

The economic downturn in rural America is compounded by a mounting crisis in access to health care services. Rural hospitals increasingly face financial jeopardy, and rural communities continue to experience

difficulty attracting and maintaining an adequate supply of physicians. To some extent these problems reflect the nature of rural living: the frequently long distances that rural families must travel in order to obtain both basic and specialty medical care and the sparse population of rural America, which makes it difficult to maintain a system of comprehensive health care services.

It is of crucial importance to recognize the close relationship between the economic viability of rural communities and the health care infrastructure. Rural communities are often economically dependent on a relatively small number of industries; they lack the diversity that protects urban communities from the changing winds of economic fortune. Within rural communities health care facilities, be they hospitals, nursing homes, or physician practices, are major contributors to the local economy in terms of providing jobs and as major purchasers of goods and services. Moreover, the decision to locate other industries in rural areas often hinges on the availability of health care. The well-being of the rural health care system serves a barometer for the general well-being of rural America.

The challenges facing rural health care providers can be characterized by a demand for health care that is far in excess of the available supply. Moreover, trend data suggest that the discrepancy between the demand for the supply of rural health care is growing larger.

On the demand side, the residents of rural America tend to be older, poorer, and less likely to be insured. According to the Bureau of Census, 25 percent of the general population resides in rural communities, while 33 percent of the elderly live in rural areas. In 1986, 17.4 percent of the urban and suburban population were uninsured, compared to 19.1 percent of the rural population. Agricultural workers and their families have especially high rates of non-coverage; nearly 32 percent of agricultural workers and their families were uninsured. Among the agricultural population living in poverty, nearly 49 percent were uninsured. Rural families tend to work for small firms or are self-employed, and, therefore, are less likely to have employer-provided health insurance coverage. Moreover, even when rural employers offer employee coverage, they are less likely to subsidize the cost of family coverage and may not cover maternity care. The effects of poverty and lack of health insurance are compounded in rural areas by the limited availability of free or subsidized care.

The poverty rate in rural areas is 33 percent higher than in urban areas. In 1985, 30 percent of rural women who gave birth had family incomes below the poverty level, and 24 percent of rural children under the age of 18 years lived in poor families. Furthermore, programs designed to alleviate the impact of poverty are more limited in predominantly rural states. Rural poor families are more likely to

include both parents, are more likely to have work-related income, and are more likely to own at least some income-producing property. As a result, rural poor families frequently fail to qualify for Aid to Families with Dependent Children (AFDC) and Medicaid, because of asset tests and the exclusion of two-parent families that work. In 1987, Medicaid covered approximately 40 percent of those living under the poverty level. In rural areas only 25 percent of the poor were covered by Medicaid.

Studies conducted in the late 1970s projected an oversupply of physicians throughout the last two decades of the century and predicted that this oversupply would result in a diffusion of physicians into rural areas. While there has been a tremendous growth in the overall supply of physicians, rural areas, especially small rural areas, have not benefited. Between 1975 and 1985, the number of office-based physicians per 100,000 population increased 38 percent in metropolitan areas, but only 33 percent in nonmetropolitan areas and only 22 percent in the smallest rural areas. In Montana's 34 counties with populations under 10,000, the supply of physicians increased only 6 percent between 1975 and 1985. The number of office-based physicians in general and family practice in nonmetropolitan areas actually declined by 3 percent between 1970 and 1986. Moreover, a recent survey suggests that as many as 25 percent of all rural physicians will retire or leave their community within the next five years.

As of March 1988, there were nearly 2,000 primary care Health Manpower Shortage Areas as defined by the Department of Health and Human Services. The population in these areas numbered nearly 34 million. More than 4,100 physicians are needed in those areas to eliminate the shortage designations. Montana has 28 designated HMSAs in which nearly 171,000 persons reside. It estimated that an additional 20 physicians are required to remove these shortage designations.

Since the early 1980s, federal programs for placing health care providers in health manpower shortage areas have been sharply reduced. At its peak the National Health Service Corps had more than 3300 providers deployed in shortage areas. With the termination of the scholarship program in 1981, the availability of new scholarship obligees has shrunk to only 222 in 1989. No new scholarships will be issued in 1989; by 1994, the last two scholarship students will be available for placement. Between 1986 and 1988, the number of rural NHSC assignees dropped by nearly 400. In 1987, Congress created a loan repayment program to replace the scholarship program. It also created a program of scholarships for students with exceptional financial need. However, both of these programs are very small, and it appears that the number of physicians who can be attracted to rural areas through the loan repayment program is quite limited.

Federal support to hospitals and medical schools for training family physicians peaked in 1978 and has subsequently decreased. The growth in family practice residencies that occurred during the 1970s and early 1980s and leveled off and may have declined slightly. Thus, the shortage of primary care providers available for rural areas is likely to become more acute.

Rural Obstetrical Care

Rural areas have higher infant mortality rates, which are thought to be due to higher rates of postneonatal mortality (deaths occurring between 28 days and one year of life). In 1986, seven of the eleven states with the highest postneonatal mortality rates were predominantly rural. The inaccessibility of obstetrical services in rural areas is well documented. In 1980, 25 percent of rural births were to women with delayed or no prenatal care, compared to 21 percent of births in metropolitan areas. Without adequate prenatal care rural women face an increased risk of fetal death. Indeed, in 1985, among black and non-white infants, the fetal death rates were 17 and 20 percent higher in rural areas than metropolitan areas, respectively.

Pregnant women living in rural areas are more likely than urban women to be poor and less likely to have health insurance. Furthermore, many rural states have failed to broaden Medicaid eligibility and facilitate

enrollment. Without health insurance pregnant women are two and a half times less likely to receive adequate prenatal care than woman who have private insurance coverage.

Rural women face a declining supply of obstetrical care providers and, because of geographic isolation, are forced to travel great distances to obtain publicly subsidized care. An examination of the trends in the availability of obstetrical providers paints a dire picture of the future. A 1987 American College of Obstetricians and Gynecologists (ACOG) survey revealed that 12 percent of its members had dropped obstetrical care and another 28 percent had reduced the care they provide to women with high-risk pregnancies. Changes in the amount of obstetrical care provided by family physicians are even more problematic. The over 40 percent of rural family physicians who provide obstetrical care play an essential role in the delivery of obstetrical services. There are a substantial number of rural areas with no obstetrician available. A 1987 AAFP survey found that of the 77 percent of members who ever included obstetrics in their practice, 64 percent had either discontinued or reduced obstetrical care. In 1980, 20 percent of AAFP members did complicated deliveries, and 13 percent did Caesarean sections. By 1988, only 11 percent provided complicated deliveries, and only 5 percent did Caesarean sections.

There are a number of factors that have contributed to the decline in the provision of obstetrical services by family physicians. The closure of rural hospitals and obstetrical units removes the necessary medical backup and support. When obstetricians or family physicians who provide obstetrical cross-coverage leave a rural area it become extremely difficult for the remaining physicians to provide obstetrical care. No single factor is more important than problems related to the cost of liability insurance. Where physicians are faced with liability premiums that exceed the income generated from obstetrical fees, they are forced to discontinue the provision of these services. Of the 64 percent of family physicians who have discontinued or reduced their obstetrical practices, 28 percent indicated that liability insurance problems were the reason for their decision. A 1988 AAFP survey found the 20 percent of its members elected not to provide obstetrical services because of the cost of liability insurance, up from five percent in 1980.

Since the mid-1980s there have been major efforts to improve access to obstetrical services through expansions in Medicaid eligibility. Unfortunately, just as the number of pregnant women covered by Medicaid has expanded, the pool of physicians available to furnish obstetrical care to any patient has shrunk. In the context of higher liability insurance premiums, Medicaid's low reimbursement levels and administrative difficulties have resulted in even fewer providers being willing to accept these patients. In 11 of the 15 most rural states, the average per

delivery cost of malpractice insurance is more than two-thirds of the Medicaid fee for obstetrical care.

Physician Reimbursement

The AAFP is concerned that the Medicare program contributes to the inability of rural communities to attract and hold physicians. Specialty and geographic differentials in Medicare physician payment have disadvantaged rural providers due to significantly lower payments for equivalent services to physicians who choose primary care specialties or who locate in rural communities.

Separate specialty fee screens have resulted in significantly lower prevailing fees for general practitioners and family physicians than for internists and surgical specialists for identically coded services. Prevailing charges for different visits are on average 24 to 73 percent higher for internists than for general practitioners.

The calculation of Medicare physician fees is influenced by the manner in which the boundaries of charge localities were drawn. In rural areas a higher proportion of charges used to calculate the prevailing charges were those of general practitioners and other primary care physicians who tended to have lower fees relative to other physicians. By contrast, the prevailing fee calculations in urban areas included a higher proportion of

fees from specialists whose fees tend to be higher. Thus, the prevailing fees in rural areas were biased downward in comparison to urban areas. For example, Medicare's rates for office visits to internists by established patients are on average 50 percent higher in urban areas than in rural areas.

Medicare specialty and geographic differentials are thought to present physicians with perverse economic incentives in regard to (1) which services to provide, (2) what specialty training to undertake, and (3) where to practice.

Physicians' choice of specialty indirectly affects what services are available to patients. Specialty differentials are thought to have contributed to a growing surplus of medical and surgical sub-specialists and to a relative shortage of primary care providers. International comparisons are useful on this point. Approximately 17 percent of all physicians in this country are general and family physicians. In Canada and Great Britain general and family physicians comprise 50 and 63 percent of all physicians, respectively.

Recent American Medical Association (AMA) data indicate that general and family physicians have lower incomes than any other specialty except pediatrics. Between 1977 and 1987 the real income of general and family physicians decreased at an annual rate of 0.3 percent while real income of

all physicians increased at an annual rate of 1.5 percent. The rising cost of medical education and the declining availability of subsidized loan programs serve as further disincentives to selecting a primary care specialty or a rural practice location.

Rural physicians are particularly sensitive to Medicare reimbursement policies, since a greater portion of their practices consist of Medicare beneficiaries. The geographic maldistribution of physicians is well documented and has not been significantly impacted by the growing supply of physicians. Rural physicians earn approximately eight percent less than their urban counterparts yet see more patients and face slightly higher professional costs. Moreover, rural physicians' incomes have risen more slowly than urban physicians' incomes while the professional expenses facing rural physicians have risen faster.

Access to physician services is only partially dependent on the geographic availability of physicians. Beneficiaries must also be able to pay for services. Financial access is, in part, dependent on physician willingness to accept assignment. Because of its specialty and geographic differentials, Medicare pays a lower percentage of billed charges for visits than for procedures and in rural rather than in urban locations. Beneficiaries have higher relative out-of-pocket expenses for primary care and rural physician services.

To the aforementioned should be added that it is simply inequitable to pay physicians in different specialties and practice locations different amounts for the same service. In effect, beneficiaries in rural areas subsidize the more expensive, but otherwise identical care received by urban beneficiaries. Moreover, specialty and geographic differentials are inconsistent with federal policies that incorporate uniform payment amounts such as social security, the federal income tax, and the Part B premium.

In its recent report to Congress the Physician Payment Review Commission (PPRC) issued a broad range of recommendations for reforming Medicare Physician payment. The centerpiece of the Commission's recommendations is a resource-based physician fee schedule, which would establish a single national fee for physician services modified only by differences in the cost of practice and professional liability insurance. While the Academy largely supports the recommendations of the Commission, we remain concerned that the commission continues to justify geographic differentials based on the presumption that there are geographic differences in the cost of practice and that urban practices are more expensive than rural practices. The PPRC has recommended utilizing a geographic multiplier that is intended to reflect geographic differences in the cost of practice.

The conclusion reached by PPRC in recommending a geographic cost-of-practice multiplier is contradicted by Medical Economics and AMA data, which show the cost of rural practice to be higher than in other locations. Recent AMA data indicate that mean professional expenses for rural physicians are $6,000 higher than for physicians in the largest metropolitan areas. Medical Economics surveys indicate a stable pattern of higher professional expenses for rural physicians both in terms of actual dollar amounts and as a percentage of gross practice revenues. The following chart shows annual practice expenses for urban, suburban and rural physicians in terms of dollar amounts and as a percentage of gross practice revenue. The dates in parentheses indicate the dates on which these data were published in Medical Economics.

Year	1982 (3/5/84)		1984 (11/11/85)		1985 (11/10/86)		1986 (9/7/87)		1987 (9/5/88)	
	$	%	$	%	$	%	$	%	$	%
Urban	52,350	35.4	61,810	36.9	60,000	36.3	60,870	43.0	91,540	43.0
Suburban	53,980	37.8	66,780	38.8	69,220	39.0	72,750	47.2	96,310	45.6
Rural	56,070	38.8	63,330	39.8	69,500	43.8	73,500	51.8	98,050	47.8

In taking a broad look at the body of data available on practice costs it is apparent that there is no compelling evidence of any systematic variation in practice costs, i.e., there is no objective support for implementing a geographic multiplier in a Medicare physician fee schedule. A valuable lesson on this matter is available to policy makers from the implementation of the Prospective Payment System. When PPS was designed

in the early 1980s, certain assumptions were made about the relative costs facing urban and rural hospitals. Because it was assumed that urban hospitals face significantly higher input costs, the urban/rural differential was built into DRG reimbursement rates. The disastrous consequences of having made that assumption are now being felt by hundreds of rural communities. Much effort is now being expended to undo the unintended effects of a faulty and unfounded assumption regarding relative costs. Policy makers would be well advised to exercise due caution before making a similar unfounded assumption in reforming Medicare physician payment.

Recommendations

I wish to take this opportunity to offer for the Bipartisan Commission's consideration a number of recommendations to address the problems in rural health care delivery. These recommendations are intended to build on the strengths of the existing rural health care delivery system and to encourage the development of solutions that are specific to the particular needs and characteristics of rural communities.

Coverage for the Uninsured

The Academy believes that the presently uninsured population should be provided access to health care through a combination of private sector and publicly funded programs. This approach is intended to build on the system of employer-provided health insurance the covers the large majority of working Americans. Our recommendation includes the following provisions.

- All employers with more than a statutorily defined number of employees should be required to provide health insurance coverage for their full-time employees and their dependents.

- Mechanisms such as regional insurance pools should be implemented to minimize the impact on small employers for which the requirement to provide insurance may cause significant hardship.

- Under the mandated employer-provided coverage, the employer should be required to pay a minimum percentage of the employees' insurance premiums, and the employees should be responsible for a portion of the premium as well as some cost sharing through the payment of a deductible and coinsurance.

- Employer-provided insurance should cover a basic range of services that includes health maintenance and disease prevention services for children, adolescents, and adults.

- The Medicaid program should be revised to provide uniform, national eligibility criteria based on income rather than on eligibility for public assistance.

- Medicaid coverage should include a uniform, basic set of services that is consistent with the services mandated under employer-provided health insurance.

- Workers and their dependents who are not covered under an employer-provided insurance program, but who qualify under the uniform Medicaid income eligibility criterion should be fully covered by the Medicaid program.

- Individuals who are not covered by employer-provided insurance and who are not eligible for Medicaid coverage should be permitted to purchase coverage from a pool funded from public and private sources. The premium, deductible, and coinsurance amounts would be determined by a sliding scale based on income.

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Obstetrical Services

In addition to the Medicaid provisions noted above, Medicaid eligibility for pregnant women, infants, and children should be expanded to include all those living in families with incomes below 200 percent of the federal poverty level. In addition, the complex and unnecessary Medicaid enrollment procedures should be modified to make the application process widely and readily available in rural areas.

Medicaid provider reimbursement levels should be raised to a level that ensures reasonable access to obstetrical services in rural areas. The level of reimbursement must recognize the actual cost of providing obstetrical care, especially the cost of liability insurance coverage.

Remedies for the obstetrical liability insurance crisis might include:

- alternative dispute resolution mechanisms such as the proposal recently developed by the American Medical Association;

- indemnification of physicians providing obstetrical care to Medicaid patients;

- reform of state tort laws; and

- o pass-through of liability insurance premium costs for Medicaid patients.

Physician Reimbursement

Notwithstanding the above discussion on the geographic multiplier, the overall impact of PPRC's recommendations on rural areas is likely to be highly positive. The resource-based fee schedule would substantially shift payment rates from procedural services to visit services and from urban practice locations to rural areas. The long-run impact of the PPRC recommendations on the accessibility of health care in rural communities may be especially positive. If Medicare physician payment reform results in a leveling of the disparity in income between specialties and across geographic areas, a significantly larger proportion of physicians might choose primary care specialties and rural practice locations.

The AAFP believes that a resource-based fee schedule offers greater potential to achieve meaningful physician reimbursement reform than anything that has occurred in many years. We have urged Congress to act this year to reform Medicare physician payment based on the PPRC recommendations.

Peer Review Organizations

Because a higher proportion of patients admitted to rural hospitals are under the care of any single attending physician, the proportion of rural physicians' cases reviewed by Peer Review Organizations is higher than their urban counterparts. It is essential that PROs recognize that rural physicians adapt their practice styles to reflect the communities in which they serve. PROs should incorporate the rural perspective in their review processes.

Medical Education and Training

The equitable treatment of rural providers under the Medicare and Medicaid programs is essential to attracting physicians to rural communities. Furthermore, the federal government should encourage medical schools to expose their students to rural practice enivronments early in clinical training. Additionally, residency programs should be encouraged to provide rotations in rural health care facilities.

Under the existing reimbursement system family practice residents are unable to generate the kind of practice revenues that residents in medical and surgical subspecialties can generate in their more inpatient-oriented training programs. Family practice residencies are, therefore, highly dependent on Medicare direct and indirect support of graduate medical education. Because family practice residency program graduates are highly

likely to choose a rural practice location, continued federal support of family practice residency programs is essential.

Conclusion

Rural Americans face health care challenges that reflect the special characteristics of the communities in which they live. Among those particularly rural characteristics are strengths that make rural health care personalized and oriented to the full range of needs that society presents to its health care providers. To no small degree the health care problems faced by rural Americans can be traced to federal and state policies that either specifically discriminate against rural residents or fail to recognize the special circumstances under which rural Americans live.

At minimum, federal health care programs must be reformed in a manner that removes the untoward and unjustified biases against rural beneficiaries and providers. Furthermore, federal health programs must accommodate the special circumstances of rural beneficiaries and build on the existing strengths in rural health care delivery. As Congress addresses the future health care needs of the nation, it must remain ever mindful of impact of its actions on the millions of Americans who live in rural communities.

It must be recognized that because of the very nature of rural communities, the Medicare and Medicaid programs, as they are presently conceived, do not provide equitable reimbursement for rural health care providers. Congress should develop a reasonable approach to ensuring access to health care services that is sufficiently flexible to meet variations in local conditions. Access to essential health care services in rural areas must be ensured. We look forward to working with the Congress in developing proposals that will allow the Medicare program to meet its obligation to provide reasonable access to health care services to rural beneficiaries.

Chairman BAUCUS. Thank you very much, doctor. I wonder if we can begin by asking you, doctor, to relate, from your experience, examples of how many more uninsured people live in rural America compared with urban America and how many more of our seniors, our elderly, tend to live in rural America as opposed to urban America. And the statistics very definitely show that, but I'd like you to expand upon that so we can nail those two points down as best we possibly can.

Dr. COOMBS. I think, first of all, as far as the question as to the disproportionate share of uninsured, I think that the fact that there are so many agriculturally based businesses that also attract a high segment of migrant or occasionally employed people who live within rural areas is one of the reasons that we have a disproportionate share of uninsured. As I mentioned, a third—perhaps as many as a third more is what we see in urban areas, and it's very difficult to meet their needs because of the lack of insurance, even though I think it's done quite successfully. It's getting larger, it's a higher number, as we see people who do not have access to health insurance because of the nature of their employment and because of the employment practices. I feel strongly that we need to address the issue in terms of mandatory insurance on the part of the employers, and I think that's one way of addressing that particular issue, because I think there are ways of approaching that.

The second question as far as the disproportionate share of elderly, I think that rural health and specifically the way we care for rural elderly is a model for the way elderly people should be cared for in this country. I think there's a sensitive, individual kind of need in the way we approach that. As I mentioned, there is a disproportionate share of elderly within the country and the rural areas, but there's also, I think, more resources for caring for them, because there's a strong sense of core family and those resources can be played upon and utilized as far as maintaining what the wishes of the patient and the family are. But there's no question that we need to lean toward innovative solutions of broadening the health care system so we can have home health, so we can have hospice, so we can extend to the rural hospital and provide for the care and the needs of those patients within their homes.

Chairman BAUCUS. Let me ask sort of the $64 question on home health care, and that's how do we generally begin to change the system to provide for the individualized care, long-term health care needs of our Nation's elderly, whether they live in the city or in the country? You know we have a system where there's almost no private health insurance for long-term health care, we have a Federal/State Medicaid system which pays only for essentially nursing home institutional care and does pay some physicians in some sense, but does not pay for hospice, respite, home health, et cetera. You mentioned more recognition as an incentive. I think that's a good idea. There's also financial incentives, but if you could sit back a minute, just sort of gut level or basic level, just what do we do to help change what we do in America so that we have a more individualized caring way of approaching the health needs of our elderly? There are a whole series of steps the elderly, long-term, need; one is in daily living, help and adjustments, then some folks help in feeding and bathing and so forth. How do we do this, how

do we get at this, and if we can, how do we begin to finance some of this, too? Just what is your sense on all of this? It's a broad open-ended question, but it's kind of to the heart of the matter where we are.

Dr. COOMBS. I think, as I explained, the transitional grant thing for hospitals is an example. My own personal feeling is you put the solutions—I think they have to be individual community feelings in any respect, that's the micro of it. We have to put the abilities to decide within the hands of individual communities and need to foster that kind of concept to develop innovative solutions. Solutions that work given the geography barriers, the special needs of the community. As an example, the rural health initiative, which was a series of grant cycles, brought to Tonasket a variety of things which still are there. They're not being used as grant funds anymore, but rather they are being supported by local support, by volunteerism, and by a variety of other activities. So I think it creates the seeds upon which innovative things should be charged.

The second thing is volunteerism. I'm not trying to get away from the money issue, because I think there has to be money there. As I mentioned, we are getting further away from the ability that we can't just pay part of the freight, we've got to pay at least what it costs to provide that care. But I want to get down to volunteerism, because I'm impressed by the tremendous amount of volunteer spirit which exists in rural America. I mentioned the prekindergarten screening process; that was something which we developed in the school system entirely on volunteer assistance. It costs us $250 a year to run the program, the total program. Not $250 a child, $250 a year. And we had 65 volunteers who would come in twice a year and help us deal with an issue which was a community issue. Now, I don't want to put the issue totally on volunteerism. The recognition created around that on rural communities, that's what rural life is built upon. It's a self-reliance.

Chairman BAUCUS. How do you encourage more volunteerism in Missoula? Volunteerism is self-reliance and is certainly a value that is valued more highly the smaller the community. You get into a community the size of Missoula, which is—it's not New York City, but it's not Ekalaka, it's in between. So how do we get more volunteerism that is sufficient among docs in Missoula, hospitals in Missoula, and other health care providers in Missoula, for example? How do you do it, only with volunteerism?

Dr. COOMBS. I think that a lot of it is, especially when—I don't have a good answer to your question, but I'm going to try and wrestle with it briefly. One of the things that I think is terribly compelling to something like that is to encourage families, for instance, who have relatives who are in need of home health or long-term care not to abrogate their responsibility, but to, in fact, create ways that they can help in a very tangible way to care for that person. Now, I think one of the problems is we haven't created enough of those avenues so that people don't feel that anything but abrogating that responsibility or you drop people off at the nursing home, that's it, you visit on Sunday, that that's the only responsibility, and I think we need to create avenues of volunteerism. In other words, ways that—we cannot require families to do that, but at least to get them involved as far as being able to provide a part of

what is done for that patient and also other patients within the community.

Chairman BAUCUS. I don't mean to pressure you too hard; are there some avenues that come to mind?

Dr. COOMBS. I'm used to being pressured, believe me.

Chairman BAUCUS. Test your self-reliance here. What are some of the avenues that come to mind?

Dr. COOMBS. As far as actually creating the——

Chairman BAUCUS. Sure.

Dr. COOMBS [continuing]. Other ways of making that happen within the community? Well, I think that you are pressing me in terms of finding an answer as far as going beyond what I've already said. Suffice to say, I think that within an urban community that—well, let's take, as an example, the obstetrical issues also in terms of the uninsured. I think there are a tremendous number of organizations which exist within communities, and in my community right now I'm dealing with the issue of sexual assault. A small boy was mutilated in our community recently. That has created outrage toward that particular issue. That's an example of where that is now being brought into something where we found out there were tremendous numbers of fragmented different ways of being able to provide care for individuals like that, individuals who don't have access to prenatal care. That is something that has led to coalitions to bring people together to talk about how do we create an organized system for providing care for those individuals. I think sometimes it takes, in other words, people knowing about that problem within the community or something that sensitizes them to bring them together to design themselves around a particular issue.

And I know, as an example, for instance, we talk a lot about the AIDS crisis, and I don't want to downplay the importance of that, but when you look at infant mortality, it doesn't hold a candle to it in terms of the number of babies that die every day in terms of poor access to care. I think there are ways to creating coalitional efforts of volunteerism and also very definite institutions within the community to focus the community toward these difficult problems.

Chairman BAUCUS. But the next panel we are going to have, a woman is going to describe the problems that she and her family have faced because they have a Down's syndrome child. Another on the panel is going to talk about the deep financial costs of dealing with someone in the family who has got Parkinson's disease and just financially devastated because we don't have a system that has private health insurance for long-term health care. What are we going to do to minimize the recurrence of these kinds of financial travesties?

Dr. COOMBS. I think there are several solutions to that. Obviously we have catastrophic problems needing to be cared for. The difficulties in caring for a disabled or developmentally disabled individual are incredible because of the tremendous fragmentation of existing activities that are within a community and being able to orchestrate the care for that individual. The care is there, but the access just isn't, to be able to access or to get to that care. As an example of that, in developmentally disabled, they don't provide

for a case worker or respite care or things like that that are important. We need to do that, and we can do that partially through volunteerism, but we need to have someone act as an advocate within the system.

Chairman BAUCUS. Why do insurance companies not provide health insurance in a more meaningful way?

Dr. COOMBS. It's not something like an appendectomy and this is where it begins and that's where it ends and it's real simple. I think we need State risk pools to deal with a lot of these activities which exist, be it all the way from devastating outcomes in terms of obstetrical care, in problems where they are predictable, such as developmentally disabled individuals; where insurance companies, the public, or various other venders put into a pool of money which can be disseminated to the individuals to help defray the cost of problems within those families.

Chairman BAUCUS. As a general rule of thumb, how much of the financial problems involved in long-term health care should be accounted for by expanded private long-term health care insurance maybe with some Federal tax, other incentives? Or, on the other hand, how much of the solution should be mandated coverage for all Americans, some kind of universal long-term, if you will, health care plan where all Americans pay income tax, payroll tax, something, so there's a minimum of health care benefits?

Dr. COOMBS. You are saying also from the private sector in terms of private insurance?

Chairman BAUCUS. How much should be private sector coverage, how much of it should be Government coverage?

Dr. COOMBS. I don't think we've done a very good job in terms of mandating things from private insurance companies. I think that's something which I think we need to address in terms of the insurance industry and their responsibility. If they're going to be in that, then I think they have to be able to do that.

An example, I know in the State of Montana, 15 years ago many private insurance companies didn't begin until the baby was 2 weeks of age, and yet the mortality, for instance, in the first 24 hours of life and the devastation that can occur during that time is equal to mortality from that time until the age of 50 years of age, and yet insurance companies got around that. That changed, and that changed through the State legislature mandating that insurance companies actually cover those individuals, that they could not discriminate, if you will, against that. I think that's something that has to be grappled with in terms of being able to address the long-term issues, also. It can't stop at a certain age, it has to be something which begins and carries lifelong. It has to address all of the issues in terms of health care.

Chairman BAUCUS. What do you think of the relative value study that is out?

Dr. COOMBS. I'm strongly in favor of relative value because I think it will intensify what I think will be better care for people. Individuals who maybe don't know what the relative value study is, what we are talking about is compensating physicians and other health care workers for the resources that they expend to provide the care. So instead of somebody getting $1,000 an hour to do an appendectomy, we will also be adjusting that so the person who sits

down to counsel the alcoholic for an hour will also get a reasonable amount of money for the resources which they expend. I think that's putting the emphasis upon better care for the patient and it doesn't create a jackpot for individuals to provide costly, interventionous kinds of procedures. I think that's the way it should be. I think it will put the doctor on the stool in front of the patient longer to talk to them, and I think that's better care for the country.

Chairman BAUCUS. One other question. As you know, when America moved from cost-based reimbursement to prospective reimbursement, the country assumed that basically all hospitals are alike and all procedures are alike, and also somewhat assumed the costs of the cities were much greater than the costs of rural America; an incorrect assumption. Consequently, there's more financial pressure on smaller hospitals under the new system than there is in big urban hospitals. Consequently, as you know, that's being readdressed, and I think in this next Congress—in this present Congress this year, we'll eliminate the rural/urban differential for DRG [diagnostic related groups] payments and also expand the definition of the sole community provider and provide to sole community cost-based reimbursement if they have fewer than 50 or maybe 75 beds, some figure like that. I think we'll get that passed.

The country made a mistake, tried to correct it. Now, if you could transfer that over to long-term health care in rural America. Are the costs in rural America greater or less compared with cities as we try to fashion a solution to a long-term health care problem? Could you address that a little? Are there lessons in acute care reimbursement that we should also apply to long-term care reimbursement?

Dr. COOMBS. I think that when we approach geographic variables, that I think we have to recognize that, first of all, I think we should go into it with the national lessons we've learned in terms of hospital care and physician care, as well, that we have to go into it with the lesson that it's not cheaper to provide to a country setting than it is in the urban settings. So that my opinion about that is that it costs an equal amount of money to provide long-term care in a rural community as it does in an urban community. When you look at that in terms of differences in the wages that have to be paid to provide that or the other differences which occur in terms of pharmaceuticals or in terms of other aspects of care, there's no difference in that, and I think that instead of starting off and penalizing an already fragile system, what we have to do is we have to go into it and say: Let's fully reimburse it; we made a mistake, let's change it later on. I don't think the mistake, though, will be there.

Chairman BAUCUS. I have no more questions to ask you. Anything else you want to get off your chest while you're here? Any points you want to make?

Dr. COOMBS. I guess I'm identifiable because I'm the only person here with a raincoat and umbrella. I was embarrassed when I got off the plane.

Chairman BAUCUS. We've had a little more moisture this year than prior, but if you want to bring us more, we'll accept it.

Dr. COOMBS. Thank you very much, Senator.

Chairman BAUCUS. We now have a panel. Are there any microphones here? We now have a panel of four people, first is Geri Larson, an R.N., director of nursing, Clark Fork Valley Hospital from Plains, MT; the second, the Torrence family from Sidney, MT, came a long way; Harry and June Higgins from Troy; Kent and Nola Olson from Florence, MT.

Now, here's what I'd like, could—Geri, you go first, and could you pull that microphone as close to you as possible so people in the back can hear? Go ahead.

STATEMENT OF GERI LARSON, R.N., DIRECTOR OF NURSING, CLARK FORK VALLEY HOSPITAL, PLAINS, MT

Ms. LARSON. Thank you. I thank you for the opportunity to be able to testify today. I'm Geri Larson, I'm the director of nursing at Clark Fork Valley Hospital, nursing home, and home health agency in Plains, MT. It's very similar to many rural hospitals in the State of Montana. I have a background working both in public health and with the developmentally disabled.

Clark Fork Valley Hospital provided family-centered obstetrical care for Sanders County up until April 1986. The hospital delivered approximately 100 babies per year to a population base of about 8,500 people. These services were family and community centered with the hospital allowing fathers in the delivery room and in the operating room for caesarean sections. Clark Fork Valley Hospital was one of the first rural hospitals in the State of Montana to utilize fetal heart monitoring. There was a staff of three family practitioners and skilled professional nursing staff providing state-of-the-art prenatal, labor, delivery, and nursery care. It was the complete community hospital. Obstetrical care was provided by physicians and hospital. Although it was a minor financial loss, it was the philosophy of our hospital to provide normal, routine community services to our population. One year prior to the closing of the obstetrical service, the hospital and physicians began to investigate ways to continue obstetrical services when they found out there would be dramatic increases in the liability insurance rates.

Sanders County is a rural, mountainous county in western Montana with one of the highest unemployment rates in the State. The rate at times can be 18 to 20 percent. Plains is the medical hub of Sanders County with the only hospital 80 country miles to the next level-of-care facility. This facility is reached by traveling over a narrow two-lane road that winds along a river with treacherous driving conditions in the winter. Access to hospital care within the county itself is difficult at best. Hot Springs, with a high elderly population, is 20 miles from Plains, but it's over a mountain pass on a narrow two-lane road rising several hundred feet in elevation with rigorous winter conditions, or 60 miles on a narrow two-lane road to the next hospital at Polson. Noxon, Trout Creek, with one of the highest snowfall areas in the State, is 60 miles to the west over two-lane roads to Plains. It's 60 to 70 miles north to Libby to a hospital, or 60 miles west to Sand Point, ID. Thompson Falls is 30 minutes from Plains. The distances between these hospitals are bare of medical facilities that provide equipment and staff to treat trauma and to deliver babies and save lives except for three some-

times-staffed physician clinics. The only thing between them are ambulance crews with training anywhere from advanced first aide to EMT's [emergency medical technician].

As a woman and a nurse, the loss of obstetrical care by health care professionals in Sanders County was frightening. Having 14 years of personal experience at the hospital assisting physicians in the delivery of obstetrical care to a population of moms with a 45 percent increased risk rate, I have experienced the sudden crisis in labor and delivery of fetal distress, the loss of oxygen and nutrition to a baby, a mother with massive hemorrhaging, a failure of a mother to be able to progress in labor, and shudder to think that during these critical stages of bringing the greatest American commodity into the world, our children, we are asking mothers to travel distances of a minimum of 60 miles, up to 140 miles, to labor and deliver. The precious moments when we know that skilled medical professionals using state-of-the-art technology can be saving not just the precious lives of mothers and babies, but the precious brain cells lost that give us dyslexia, cerebral palsy, mental retardation, and in some cases brain death.

I'd like to share examples of the problems faced. A Medicaid mother, 17 years old, arrives at the hospital in premature labor 3 months early. She had one prenatal visit early in her pregnancy and could not afford to travel the 110 miles that were required for further care. She had been in labor for over 48 hours hoping that it will stop, but when she finally decides that she must do something, she arrives at the hospital in Plains after borrowing a car and gas money. She is completely dilated and ready to deliver at a hospital with staff that is no longer able to deliver babies except in true emergencies. Missoula Community Intensive Care Nursery Team are called at 2 hours away. Labor has progressed too far to transport or for the labor to be stopped. Fortunately the baby waits until the transport team arrives, is stabilized and taken to Missoula, and later transported to Salt Lake City for more intensive care. The baby dies due to prematurity, the parents are devastated, and thousands of dollars are expended when a few hundred dollars could have been spent to provide prenatal care in this young family's own community and delivered full term at her local hospital 26 miles away.

Another mother arrives at midnight at the hospital. The roads are snowpacked and icy, the wind is blowing. She believes herself in labor, is frightened about whether it is safe for her to travel the 80 miles in these conditions or if she will deliver on the way. Her progress is checked and reported to her Missoula physician, who also becomes concerned whether this patient is safe to make it to Missoula for delivery. Already an hour has passed and the decision is made to send a frightened young couple down the road. And they make it, but the stress shared by everyone is great.

A lay person assisting with a home labor and delivery calls the hospital. The mother, they believe, has been in labor for 48 hours with membranes ruptured, has had one physician visit early to determine she is pregnant. The midwife believes she can see the baby's head, but the mother cannot deliver. Arriving at the hospital by ambulance, it is determined that the mother is not in labor, not dilated, and not ready to deliver.

Is this what America has come to, that we allow the greatest health care delivery system in the world to be turned back centuries into untrained hands, endangering the cornerstone of our own society, our youth. The limited options are for our mothers, babies, health care workers, longer travel at the worst possible time, lack of family and community bonding to the infant, increase in newborn injury, loss of skilled medical professionals.

Yes, Clark Fork Valley Hospital considered the option of paying for physicians' liability insurance, but in order to maintain an emergency room and a hospital for the community, liability insurance forced us to drop our obstetrical services. As a small rural hospital, we struggle daily to maintain a financial bottomline that will help us to avert this same crisis in other areas, such as our emergency room, our hospital, our home health care, and our nursing home. We hope that we will be able to be reimbursed adequately and on time and that we will be able to continue to provide adequate access to health care for the people of Sanders County. Thank you.

[The prepared statement of Ms. Larson follows:]

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June 23, 1989

Testimony Presented to Pepper Commission, June 28, 1989, Accessing Rural Health Care:

Geri Larson, R.N., B.S.N.
23 years experience
Presently Director of Nursing Service at Clark Fork Valley Hospital, Nursing Home and Home Health Agency. Position held for 16 years.
Former Public Health Nurse and Coordinator of Western Montana Child Development center. This covered 7 counties.
Former Head Nurse of Newborn Intensive Care Nurserys of California Hospital Medical Center at Los Angeles CA.
County Public Health Nurse in southern Idaho with 150 developmentally disabled youth.

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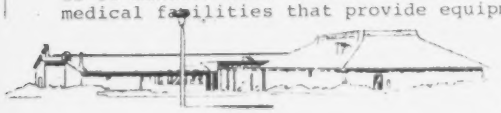

deliver babies and save lives except for 3 sometimes staffed physician clinics, ambulance crews with training from Advanced First Aid to EMTs.

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Is this what America has come to , that we allow the greatest health care delivery system in the world to be turned back centuries into the untrained hands endangering the cornerstone of our society, our youth.

Consequences: Fear, stress, limited option for mothers, babies, health care workers. Longer travel at worst possible time, lack of family and community bonding to infant. Increase in newborn injury, loss of skilled medical professional.

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Chairman BAUCUS. Thank you, Mrs. Larson. Mrs. Torrence, you're next. You've come a great distance, Mrs. Torrence. How many miles is it to Sidney?

STATEMENT OF RUTH TORRENCE, SIDNEY, MT

Mrs. TORRENCE. According to the map, 545. I think we've driven 610 one way. My name is Ruth Torrence. I'm here from Sidney, MT, which is almost on the North Dakota border. My husband, Dave, and son, Ben, are sitting here in the corner. I'm a mother of three children, two of whom have severe developmental disabilities. I'd like to tell you about the difficulties we have had getting appropriate care for our children and for my mother.

In 1968 our first child, Tanya, was born with extreme mental retardation. Now 21 years old, she has a 1-year-old age capacity. Trying to care for Tanya during the first few years was extremely difficult. She required full-time care and there was no one in our small community of Sidney to help provide it.

When Tanya was 2, my mother had a stroke. At that time she was living 280 miles away in Billings. During the stroke she fell and dislocated her shoulder. That meant she couldn't continue to live alone. Had there been home care services, mother could have stayed at home or lived with one of her daughters. Instead she spent the last 11 years of her life in a nursing home in Sidney.

The first 2 years was tremendously difficult. I visited my mother at least three times a week to see that her medical needs were being met. My mother was in and out of the hospital with problems. I was pregnant with our second child. We didn't have the money for a baby-sitter for Tanya because of the cost of her birth. That meant that I was literally tied to her.

By the time Tanya was 3, we were faced with the most difficult decision a parent can face. Between Tanya, my mother, and our newborn baby, I had more than I could handle. Our town did not have the medical services that Tanya required. Under the current system, assistance is either all our nothing, with extremely long waits for placement in a program. Our family was left with two options: Try to cope ourselves and hope that we were not destroyed emotionally and financially, or place her in the care of the State.

It became clear that we could not provide full-time care for Tanya and survive emotionally. She didn't eat, could not walk, and she is still that way. So we placed her in the Boulder River School and Hospital outside of Helena, nearly 500 miles away from our home. She stayed there until age 11. At that point she was placed in foster care with a family in Big Timber. About 5 years later some conflicts began to arise and the foster mother indicated that she could no longer handle Tanya. At that time we placed her in a small group home and sheltered workshop program in Helena.

It was hard for us to be enthusiastic about her original placement at Boulder River. Institutions are not nice places to visit, especially if your own relatives live there. The home atmosphere was certainly better at Big Timber, but stability is also important. She has been in the group home for 8 to 10 years now. Since it is so far from our home, we only get to see Tanya about once a year.

Our third child, Ben, has Down's syndrome. He is 16 now and will soon be too old for high school in about 3 or 4 years. Counselors have told us that there will be about a 2 year wait before he can get into the sheltered workshop program in Sidney. I think the wait will be much longer. In our area the program is already serving two more than they are being paid for, and in Ben's class there are three older children who are already part of the developmental disability system who will have priority. Trying for a placement somewhere else is also not an option. For Ben, living on his own would be a death sentence. On his ninth birthday he wound up in the hospital with diabetes. This requires daily monitoring. He can't measure his insulin levels, give himself shots, or measure his blood sugar levels. Our biggest concern is for his future medical costs. Once he is 21, if he is not in school, he will no longer be eligible for our insurance. And if he is living at home, it is unlikely that he will qualify for Social Security or Medicare, so we must prepare to bear inevitable future medical expenses ourselves.

Our experience with our children and my mother has been made more difficult and more emotionally devastating by a system which is indifferent to the needs of families. Both my mother and my daughter were institutionalized prematurely due to the lack of community-based support services. My son now faces difficulties finding appropriate placement in the community, as well. I hope the Commission will remember that families in rural America have the same needs for health and long-term care as the rest of the country. Thank you, Senator.

Chairman BAUCUS. Thank you very, very much, Mrs. Torrence. Next is Harry and June Higgins.

Mr. HIGGINS. Thank you, Senator. After listening to my neighbor here, I don't think my story is quite as sad as I thought it was. You're a great inspiration, Senator. I want to thank you for this opportunity to be here. I've never had the pleasure of meeting you before. However, I am very good friends of Earl Reilly.

Chairman BAUCUS. Harry, bring that microphone very close to you.

Mr. HIGGINS. Can you hear me now? Maybe I should start all over again. I was congratulating my neighbor here, thinking that my problem is not as bad as I actually thought it was when we started into this, and I'm sure there are going to be other tragedies that will come to your concern and attention here before this is over here today. I started to tell you about your friend, Earl Reilly. We grew up together. He stayed in our home many times and we have stayed with him in Helena, so it's a great dissatisfaction to hear of his death a couple days ago. I don't seem to be nervous, but maybe this microphone is.

Chairman BAUCUS. You're doing a very good job, I tell you.

STATEMENT OF HARRY HIGGINS, TROY, MT

Mr. HIGGINS. Senator Baucus, my name is Harry Higgins. I'm here with my wife, June. We live in Troy, MT, a small town in northwestern Montana near the Canadian border. I'd like to share with you the problems I have had in getting proper health care for my wife in the rural area where we live. I might mention that we

live in this rural area the same as all these other people in Montana do, because we love that part of our form of life. We'd probably do better as far as medical health goes to be closer to the cities, but we don't want to be near the cities, it's not in our religion to be close to the city.

About 15 years ago my wife was diagnosed as having Parkinson's disease. Up until a couple of years ago, her symptoms were very, very mild. In November 1987, she started to have real problems. Around Christmastime, we had an emergency. We were in Moses Lake in Washington where we had lived for many years and where June's doctors were. We were hoping to get to see June's doctor, but he was on vacation. In the middle of the night, June awoke experiencing hallucinations, screaming, and scared half to death. I drove her to the hospital. June's condition got worse as we drove. The doctor in the emergency room gave her a pill, but would not admit her to the hospital, and the pill did not help one bit.

Before this incident, we had set up an appointment with her doctor for late January. While we waited for the appointment, my wife continued to experience hallucinations and the doctor decided to put my wife on a drug holiday. I might mention about this term "holiday." I've never heard it before and I've never heard it since; to absolutely take the patient off all her drugs at the same time. That night she came all apart and we rushed her back to the emergency hospital at Moses Lake and there they administered to her a drug by the name of Haladol. I might mention at this time, if anybody wants to take a real good look at the drug Haladol, it is most vicious of any on the market. Maybe Dr. Coombs has run into that someplace along the way. The tragic part of this thing was as they administered this drug to her, I could see her change very, very badly for the worse. They administered to her three different doses of Haladol, first 4 milligrams and then 2 and then 2. As she laid there on that stretcher and three of my children were with me, we all went through living hell seeing the torture she had to go through. But now she seems to be much on the improvement since I've had her home for the last 4 or 5 weeks.

Now, since that time we have found out that Haladol is never to be administered to a Parkinson's patient, to a diabetic, and to anybody in a highly extreme emotional condition at the time it's being administered.

Over the last 1½ years, June has been home for a total of 2 months. June has been in nursing homes in Idaho, Washington, Montana, hospitals from coast to coast. We've been back in Washington, DC, and started with Virginia Mason out in Seattle, WA, and each one of these seemed to run in a cycle of about 30 days at a time, so we've got to see a lot of doctors, a lot of specialists, and also a lot of traveling and a lot of living in motel rooms and out of suitcases. And it's been quite a physical strain on myself, my wife, and a financial one as well. I drove weekly to the nursing home in Washington State, a trip that took 5 hours each way. The nursing home cost was as high as $2,650 a month, with other expenses on top of that; like a motel room, it costs you around $460 a month, you had to eat out, and you have to buy special clothing, special braces, special shoes.

We are covered with Medicare, thank God for that program, and we also have a supplement, but on the outside of that, in a nursing home that is pretty well eaten up. We have had to consolidate our type of living and we do not have much money necessary to carry on personal types of living. Over the last 18 months we have virtually exhausted our nest egg of over $40,000. Before this all started, we were sitting on easy street for a retired couple. We had a nice home, we lived an active life, we planned on traveling. Now it's down to a matter of survival. Our income just covers our expenses and we break even.

For the past month June has been home with me. Her doctor had told us that she would be in the nursing home for the rest of her life, but he changed her medication and she's showed improvement. Since she has been at home, she's gotten better as time has passed. We just celebrated our 50th anniversary——

Chairman BAUCUS. Congratulations.

Mr. HIGGINS [continuing]. And our family is giving us a big blowout on July 9. The other day June was going over the guest list and thought of names she had overlooked. She can now move around a little bit. She can now get around with very little support at home by moving around from piece of furniture to piece of furniture. Normally she does wear braces on both legs, which we do—we have them in the vehicle, but she does not have them on today. They are too heavy and too cumbersome. You certainly would not want to go out dancing with those braces on.

Caring for her at home is not easy. A nurse's aide comes in once a day to bathe her. I do the cooking, feed her, do the laundry, and take care of the house. A housekeeper comes in once every 2 weeks to give the house a thorough cleaning. We manage to get by on a monthly income. It's hard finding qualified people out here to help care for June, and if you find someone, they are very expensive, since they are so much in demand. I would have brought June home much sooner, but I just couldn't find the people to help. I don't mind the work involved in caring for my wife. Seeing her improvement since she's been at home has been reward enough.

I've worked hard. In fact, we both have. We've been workaholics and we've raised six children and they are workaholics, so we feel we've done our service to mankind. My business was hardware for 25 years and then farming along with that, and God gave us a great gift in the ability to know how to work and how to produce. We've hired lots of people both in the business and on the farm. As I mentioned, we raised six children, four of our own and two adopted. On that belief, we now are faced with the prospect that if we have another crisis, that we will have to sell our home. We should not have to end up this way after a life of hard work. And I might add that one thing I think we pray and hope most for is we still maintain our dignity. Thank you.

Chairman BAUCUS. Thank you very, very much. Our final members of this panel, Kent and Nola Olson. Go ahead, Nola.

Mrs. OLSON. I don't know how my voice will pick up, it's fairly weak. Is that all right?

Chairman BAUCUS. You bet.

STATEMENT OF NOLA OLSON, FLORENCE, MT

Mrs. OLSON. My name is Nola Olson. I'm here today with my husband, Kent. We live in Florence, MT. Our six children are grown and out of the house, except for our youngest, who is home from college for the summer.

With some health problems, it seems your condition deteriorates rather gradually. You have time to adjust as you go. We didn't have that luxury. Everything changed for us immediately and drastically and we were so ill-prepared to deal with it.

In April 1987 I was a busy independent person doing errands, tending to the house, spending time with our 12 grandchildren. Up until 2 years before, I had worked in the office of my husband's contracting business handling the books and doing secretary work. Our son, who we had hired to replace me, was leaving in the end of June and I was planning on going back to work. Those plans were never fully realized. We were returning from my mother's funeral when we were involved in a car accident in Idaho. My neck was broken. I was taken to a local hospital where surgery was performed and I remained there for 2 weeks. The bill was $14,000. After that, I was placed in a rehabilitation hospital in Montana for 2 months. By the time of my release, my bill there was $47,000. Since I had no insurance, we owed $61,000 ourselves. Just a few months before, my husband and I had decided to let our insurance lapse. We didn't need it, we had never used it. Two years later, despite our best efforts and the support of the fund raising of our friends and community, we still owe $39,000.

As you can see, the accident left me a quadriplegic. I'm paralyzed from the breast area down. I have little use of my hands, but my arms are fairly usable, thank goodness. My hands and the underside of my arms are numb. There are many adjustments which have to be made when you are paralyzed. Your blood pressure drops, your pulse and temperature are low. At first you are just caught up in trying to breathe. You have to learn to sit up. It took me about a year to learn to do that and not feel like I was going to pass out. You must watch being out in the sun; since the nerves are damaged, I can't sweat.

I depend very much on my husband. The fact that our home is not wheelchair accessible makes his job all that much harder. Our house is a split entry, so Kent built a lift, which he operates manually to get me to the deck and entry level. Our bathroom is too small for the wheelchair, so he has to transfer me to a folding chair with wheels and wheels me in and out.

Because of my condition, I'm now uninsurable. This means all my health needs must be paid out-of-pocket. I require a variety of medical supplies, which we pay ourselves. Because it is all so expensive, I try to avoid needing care as much as possible. That means we must monitor my condition closely to catch potential problems early. Respiratory and bladder infections are a constant threat. Since the accident I've only been to the doctor's office three times. I need physical therapy, but do not receive it because there are no funds.

My situation will remain for the rest of my life. We have no assistance in tending to my ongoing long-term care needs. We

manage now, but I wonder what would happen—will happen if my condition worsens. We can't afford more help. I don't know how we could handle a problem that required hospitalization. And what if something should happen to Kent? I don't know how we would manage. No one really should have to live so precariously. Thank you.

Chairman BAUCUS. Thank you, Nola, very much. One thing is clear, all of you are a tremendous testament, an inspiration to—and all of you in this room—those of you who know your condition and have watched how you've coped. It's very, very admirable and a tremendous strength and inspiration and I just personally want to tell you how much I admire your courage in the face of all that you've been through and the inspiration you've given all of us, and I want to thank you. And I know that's not much solace for all that you've gone through, but personally it means a lot and I know it does for other Montanans and others who know you and work with you, and you ought to be commended for all of that.

It's very clear that we have a health care system where private insurance and also Medicare has a system which compensates some, although it's not entirely adequate; acute hospital care and some physician reimbursement for, say, daily ordinary visits to the doctor. But we also have a system that in no way, for all intents and purposes, through either private insurance or through Medicare, Medicaid, and other programs, compensates for and takes care of or addresses problems facing disabled Americans and problems facing elderly Americans as they begin to have certain health care needs. It's a perversity, the system we now have. It makes no sense whatsoever for this country to have a health care system where neither the private sector nor the public sector begins to address the problems that you've all outlined. The problems you've outlined are severe and you are not complaining about it, but you are suffering and have suffered very significantly and they are problems that many, many other Americans are suffering, too. And certainly the points you've made today help dramatize that gigantic void that must be addressed.

Now, I guess one question I'd like to ask all of you, a point maybe all of you could make, is whether when you were younger, say, you, Mrs. Torrence, before the children, thought about trying to save money for potential disability or save for potential long-term health care costs. We're in the yuppy generation here in America today and I doubt seriously whether very many people save, have savings accounts or whatnot, because private insurance isn't available to cover this and there's no Federal program or State program to cover this. If you could, just looking back, let's talk, let's voice your thoughts and feelings, say, Mrs. Torrence, before you had children or when you were younger. The degree you would have saved to try to take care of not only you, Mr. Higgins, for your retirement, but also potential problems that your wife has suffered, if you could address that. What I'm trying to get at, I don't think very many Americans on their own save for problems like this and we have to have a better system through private health insurance or Medicare or Medicaid to address this.

Mrs. TORRENCE. Well, when my husband started teaching, he earned $4,000 a year and we were helping support my mother, and

on that we didn't have enough to have a child, much less save for future medical costs. We are very fortunate, in that we are, at this point, covered by insurance. My mother fell into Medicare, Medicaid, and Social Security, and the latter years our daughter had been covered under Social Security, and that's one of the reasons there's so much trouble, when you pay out the tremendous amount that you paid in Social Security on this 21-year-old child, the costs have been horrendous. Yeah, we are saving money, but on $4,000 a year—when she was born his salary was $6,000 and he worked for two summers in the Sidney Grant Program. The entire money went to the hospital bill because she was in the hospital for 65 days. That was just at the very beginning.

We are far more fortunate than the other two couples here, but people should not have to go into abject poverty to live. Because once an elderly couple is caught into this, once the one of them is gone that needs the care, the other one still has to live, and what do we do with the one that's living? Or if the one that does not need the health care dies, what happens to the other one? As she says, what will she do if something happens to her husband? And the tremendous costs there at $2,000 a month will destroy a home in 2 or 3 years and destroy a rather large savings account in 2 or 3 years.

Chairman BAUCUS. Mr. Higgins, do you have any thoughts on that point?

Mr. HIGGINS. Senator, I have them. I don't know how appropriate they would be if I expressed my mind in full.

Chairman BAUCUS. Here is your chance.

Mr. HIGGINS. No. 1, raising six children they called me millionaire Higgins, and I had to be to raise those six kids; by the time you clothe them and feed them and educate them, they all have the educations they wanted, most of them have their degrees. We know what it is raising a family and giving them the things they have and activities and church and other organizations. But we are proud of every one of them, the way they turned out, so we have that, but we have never been able to save money for our retirement after they were gone and we're too old to work and too old to produce very much, and at one time when my wife did work, she had a fine insurance policy with bond retirement. Her policy terminated because it was a group policy and didn't go with the party when they retired.

Senator, as I see this overall thing and what we've heard here today, what I can read in the papers and what I've seen on the news and in the magazines, we've got one hell of a big problem. And it's not only in our locality, it's not only in the State of Montana, it's more so on the rural end of it out here because we do not have the facilities that the cities have, but this thing is pretty generally throughout the entire United States. I know Senator Pepper did a fantastic job and what I can read about you, Senator, you are doing a very good job on this committee, and we just wish you well and hope we can work with you in whatever your problems might be. I might ask my wife, she would like to say something, she usually does.

Chairman BAUCUS. OK, June.

Mrs. HIGGINS. I hardly think that that was necessary.

Mr. HIGGINS. I didn't mean it that way.

Mrs. HIGGINS. I think this has been a very informative bit today. When I get to—with my Parkinson's and my other thing, I can't talk very well, so I wish everybody well and hope that those that have these problems can work with them and our State and Federal people will work with us, too.

Chairman BAUCUS. Thank you very much, June. Kent, I think I cut you off, didn't give you a chance to——

Mr. OLSON. That's perfectly all right.

Chairman BAUCUS. Anything you want to add?

STATEMENT OF KENT OLSON, FLORENCE, MT

Mr. OLSON. Well, I did have some thoughts down here. I wanted to say a little bit about the impact that Nola's accident has had on our lives, as well as on our business. We own a contracting business. The year before the accident we looked at our yearend financial statement and we noticed that the profit that we had made was about the same as what we were paying for health and accident insurance, so we thought that if we dropped the insurance, we might be able to get ahead a little bit. And since we were always very healthy people, it seemed like money down the drain. But, in fact, that didn't turn out to be the way it was.

In addition to the $70,000 in hospital and doctor bills, the business lost $60,000 during the year of the accident, and that's not easy to come back from. With Nola in the hospital, I had no time to bid the jobs, and when we were able to bid jobs, we had trouble getting the bids because the economy is so tight in our area. It seemed that we were always a little bit high with our bids. We didn't have a job for some time after the accident. In addition, we bid jobs that require bonding, and the amount that we can bond for is based on our net worth. We lost a lot of bonding capacity, and at a time when we were trying to climb out from under a mountain of debts, we couldn't bid on jobs that were big enough to show much profit on.

Since the accident our daily routines have completely changed. On the three mornings a week when Nola showers, I have to transfer her to a chair with wheels to go into the bathroom and then again to a chair in the shower itself. And after the shower, then I have to go all through the transfers in reverse. I put on a binder each morning to help her with her breathing and her blood pressure and I put on special hose to help the circulation in her legs and I dress her and do her hair and put her makeup on, and this whole routine takes about 2 hours. And then I fix breakfast, and after that sometimes Nola does her exercises to build her strength and other days she exercises in the afternoons or evenings, whenever we can fit them in.

Then we go to the office, which is behind the house, and Nola helps with the paperwork. She can type fairly well now with two fingers. She does the payroll checks and the submittals and contracts. We have a telephone with a speaker that she can use. She did the books for many years before the accident, so she supervises the person that we've hired to do the book work.

The accident had a big impact on how we run our business. Since I'm Nola's only caregiver, I can't leave her for very long. Because of the paralysis, it's necessary that she be catheterized every 4 or 5 hours, including during the night, and that means that I can't go out to the job site and act as a superintendent on the job. Up until the accident I supervised the jobs on the job site. Now we have to hire someone to do that. The first job that we got after the accident, my dad, who used to work in our business, came out of retirement to be the job superintendent. As Nola mentioned, before the accident she was planning to go back to work full time to handle business books and paperwork. Because of her condition, we had to hire someone in addition to her. These extra salaries are a burden on the business and makes it harder for us to turn a profit.

Right now the business is almost staying even with the board. We finished the job that my dad helped us with and we're doing another job now. We're bidding for a job to start after this one ends, but the competition in the construction business is very tight. Our office overhead has been eating up any profits. My wife and I are unable to contribute as fully as we should. If we don't line up another job soon, we'll be losing money again.

Finances at home are also tight. Before the accident, after we finished a job, we'd go on half salary in the office until we got another job. We were on half salary when the accident occurred and have been since. If we took any more money now, we'd be losing money in the company. We don't qualify for any State or Federal programs. It seems that as long as you have a job, you are disqualified for any of those things. We thought that we were in pretty good shape financially before this happened, but it doesn't take long for medical bills to change those things.

Chairman BAUCUS. Thank you very much, Kent. I might ask, do any of you have any ideas on what some of the solutions might be? I mean, should we change maybe the Tax Code so that private health insurance is much more available, much more affordable? Some say that even then private health insurance is quite expensive, and basically you all indicated that you didn't really have the income to provide for savings, and maybe, therefore, also not able to pay for long-term health insurance. Mr. Olson, you indicated that that was a problem in your case. Or do you think all Americans should pay an income tax surcharge or mandate a payment to some kind of a program to reimburse some folks who have suffered disabilities or long-term health care infirmities? I wonder if you've—I'm sure you've given some thought to what each of you have been through. I'm curious to potential ideas you might have.

Mr. OLSON. I suppose our personal financial problems aren't a great deal different than the Federal. We either need more income or less expenses. Insurance costs are terrifically high, medical costs are even higher if you don't have insurance, so I don't know what the answer is, but I can tell you the problems, I guess.

Chairman BAUCUS. Part of the problem is this: We are talking about, for probably most Americans, a low risk, but high cost problem. That is, the risk of Americans being disabled or the risk of a nursing home, institutionalization for, say, 2 years is fairly low, but the cost is exceedingly high. And it seems to me that, therefore, the solution is a pooling somehow, broad-based small contribution by a

lot of people so that those few people who do incur that cost are then able to tap into the pool of resources that have been built up. It seems to me whether it's public or private or a combination, it's going to have to be something like that to tend to address some of the problems that you've all described.

Mrs. TORRENCE. I agree with you, Senator, that there should be a mandated payment for catastrophic illness. As I listen to people and see things, I think that one thing that would help here is accessibility to some kind of respite for all these people. You can only give it so long. Ben goes to school, I get respite when he goes to school. And not necessarily based on family income. The Federal Government wants to base everything on family income and people shouldn't have to be destroyed financially in order not to have this happen. And this would help both of these families, a respite situation. Dr. Coombs mentioned volunteers. I know of one person in Sidney that I could ask to take care of Ben who could handle both a mental retardation and the diabetes. That happens to be a nurse. I have tried to get people under a paid system of respite for very severely involved children in Sidney and have been turned down, and so a system of volunteers is not entirely realistic.

Chairman BAUCUS. I've got some sense of what you are talking about, but not a lot. I take off 1 day a month each month and work in a different job in the State. For example, just yesterday I worked here in Missoula, it's called Sun Mountain Sports, it's a company that makes golf bags. Several months ago I worked for a home health care agency in Helena and I spent several hours with a woman whose husband had Alzheimer's, and it was astonishing to me, an eye opener to me, she had to be with him every second of the day. She bathed him, fed him, took care of him. I only helped for 3 hours. She has to be with him 24 hours every day, every week, and every month, and it's clear to me that she needed some type of respite, someone to help out. I also spent several hours helping a man, college professor, who suffered an aneurysm and basically he is disabled. Spent hours with him just basically going through the directions, helping him put a toy together, to rebuild, regain some of his lost skills, and then a couple of hours with a man in his home trying to take care of his wife. He would do anything to keep her out of a nursing home. The time and attention he would spend with her, all the things that had to be done for her was astounding.

All I'm saying is I know what you are saying; very small sliver and slice I've got a sense of what you are talking about. Some respite care, that's part of the solution. There's much more to it.

Mrs. TORRENCE. No one can continue to give 24-hours-a-day, 7-days-a-week care forever. No one can handle it.

Chairman BAUCUS. Any of you have anything else you would like to say?

Ms. LARSON. I would just like to mention one thing. In hospitals, nursing homes, home health agencies, the reimbursement for the actual cost from the Government is not adequate to meet the needs of the facilities, and one of the things that I see as something that should be considered, the regulation that comes down, and I fully understand that in areas and in certain situations the regulations are there for the protection of the patients, of the residents, of the

nursing home, of the hospital, and so on, but sometimes those regulations, as they are determined by Congress, are interpreted by other people and to the detail in which they are interpreted and the cost then that comes down to health care facilities is overwhelming.

Chairman BAUCUS. You are talking about the intermediaries?

Ms. LARSON. I'm talking about the regulations that are required by nursing homes. It doesn't matter if it's Medicare——

Chairman BAUCUS. Somebody is going to come up a little later today, a person who represents nursing homes and also another person, Mr. Cain, from Blue Cross and Blue Shield, who tends to be an intermediary to the degree that he's got to go through the Government regulations and reimbursement policies. Is there anything that he should know or hear, they should know or hear?

Ms. LARSON. Yes; I would like to say loud and clear that when you run a tight ship and you do a good job and the people in the nursing home and home health care agency, your hospital are receiving good care, they come in with the regulations and their determination of what is required as far as documentation to prove to them about the health care that's being delivered is overwhelming, and as a nurse I have gone from the bedside now to the office because I would say that in the time that I have been a nurse in 23 years, the paperwork has increased by 60 percent. It's not increased to improve the care of the patient, it's to prove to the intermediaries that we are providing the care that we say we are providing.

Chairman BAUCUS. You touched a nerve there, I can tell. Do any of you know much about the Canadian health care system? Are there any lessons there? Yes, Mr. Higgins.

Mr. HIGGINS. About 2 years ago we got tied up in a wreck in Canada. I got a couple of broken ribs, June didn't seem to be hurt at all, but they rushed me to emergency, and that was by ambulance. I was with the doctor off and on for 2 hours, they took 8 x rays and I spent time interviewing other people that were involved in the wreck and everything. The total bill came to $68; $28 for the doctor, he spent 2 hours with me, and the rest of it for x rays and ambulance service. Now, I'm a Canadian by birth. I have never used any of their Medicare——

Chairman BAUCUS. You are entitled to that because you are Canadian?

Mr. HIGGINS. No; I wouldn't be. You have to be a resident, sir, I think for the last 15 years if you wanted to get with the program. But it's interesting to see what they did charge and how well they are getting along. We have a lot of relatives in Canada and they are doing fine with it. They take care of all emergencies immediately, but on surgeon operations you have to wait your turn. There's always a small waiting time before they can take care of you. But it is working and it's working fine, and we just had visitors in our home from Canada 2 weeks ago, my aunt and another fellow, and he, too, has a dual citizenship, the same as I have, but he is studying the Canadian health program and comparing it to the United States and he says they are far superior and they are doing it most economical.

Chairman BAUCUS. Thank you. Anyone else have anything he or she wants to say while we have the opportunity? I want to thank the panel very, very much for your time and efforts you have undertaken. We are going to take a 10-minute break; that is 5 minutes after 3 o'clock we are going to be getting in.

[Whereupon, the hearing was in recess at 2:55 p.m., and subsequently reconvened at 3:15 p.m., and the following proceedings were had and entered of record.]

Chairman BAUCUS. OK, folks, let's get back to business again. If everybody will please have a seat. This has been a 20-minute break, not 10 minutes. If everyone could please have a seat. Everyone please take your seats so we can begin so we can be courteous to our witnesses. They have very important statements to make, many have traveled long distances, as well, and they are all, I know them, good people. They have a lot to say. I think they will be very helpful.

Let's now turn to our next panel. This panel is essentially one of people who are directly associated with various health provider associations in our State, hospitals, Blue Cross-Blue Shield, nursing homes, home health care associations, and directors, so they have also a very valuable contribution to some of the problems we're trying to address here today. I'll first turn to Mr. Bill Downer, who is the president of Columbus Hospital. I've known Mr. Downer some time and he's a man who has worked very hard to help provide good acute care service and other similar care services in our State. And, Bill, I'm very happy to have you here.

STATEMENT OF WILLIAM J. DOWNER, JR., CHAIRMAN, MONTANA HOSPITAL ASSOCIATION; PRESIDENT AND CHIEF EXECUTIVE OFFICER, COLUMBUS HOSPITAL, GREAT FALLS, MT

Mr. DOWNER. Thank you, Senator Baucus, for the opportunity to be here. It's good to see you again. My name is William J. Downer, Jr. I am the president and chief executive officer of Columbus Hospital——

Chairman BAUCUS. If you could bring that microphone——

Mr. DOWNER. I'll lift it up. If it starts feeding back, tell me. I'm the president and chief executive officer of Columbus Hospital in Great Falls, MT. I'm also the chairman elect of the Montana Hospital Association [MHA]. It's a pleasure to appear here today before you on behalf of the hospital field here in Montana.

Health care policy in the United States has been rooted in the belief that quality health care should be provided for all citizens. Our goal as an association, and my own personal goal as a hospital chief executive officer, has been to provide access to that health care to all Americans on a high quality, affordable basis.

Nearly 25 years ago, and, yes, I was there when it happened, Congress took a revolutionary step toward fulfilling this goal when it created Medicare and Medicaid. Through these two programs, two medically disenfranchised groups, the elderly and the poor, were promised the same access to health care that millions of Americans already enjoyed. However, despite the successes of these two programs, we are still far from realizing these goals.

We at the MHA believe that an underlying cause of the shortcomings in the provision of access to both medical care generally and long-term care specifically can be traced to the Medicaid Program. Medicaid, as originally envisioned, was supposed to make sure that everyone, regardless of ability to pay, had access to health care. But Medicaid has failed to fulfill this objective. In 1975, 63 percent of low-income Americans were covered by Medicaid. By 1984, this figure had dropped to less than 40 percent of the persons living below the Federal poverty guidelines.

In explaining this, I want to turn to long-term care. The original framers of Medicaid never intended that the major source of payment for long-term care would come from Medicaid. Long-term care is currently, with limited exceptions, financed with the personal equity of those who receive the care. When their resources are exhausted, Medicaid then takes over payment. But the system is bankrupting elderly Americans and at the same time making Medicaid the primary source of long-term care funding. Half of Medicaid's expenditures nationally are for long-term care. Another 25 percent are used to purchase Medicare Part B coverage and supplemental coverage for services not provided by Medicare. In other words, the nonelderly poor are being squeezed out of Medicaid as it becomes the public supplemental insurance for Medicare.

Montana Hospital Association believes the time has come for a comprehensive overhaul of the way long-term care is financed. We need to devise a way to finance long-term care that does not force elderly Americans into poverty. We need to develop a public/private insurance partnership to finance long-term care. And we need to get Medicaid out of the business of financing long-term care and back into what was envisioned as its original business of providing access to health care for the poor generally.

In our view, there are several financing proposals that should be considered. Tax incentives could be used to encourage individuals and/or employers to finance long-term care insurance voluntarily. Employers could be required to provide long-term care benefits to their employees. Or such benefits could be provided through an expansion of Medicare Part A or by creating a new Medicare Part C. Each of the plans has merit. Each should be examined closely. America's population is graying and the demand for long-term care will continue to grow. Unless a comprehensive plan is developed soon, America's health care providers will no longer be able to meet the demands for long-term care.

The elderly will not be the only losers if this happens, however. Without a comprehensive reform plan, the next generation of poor mothers and children face a future in which the doors of access to America's health system are closed. In Montana, Medicaid reimbursements are falling farther and farther behind the cost of providing the care. In 1987, hospitals billed Medicaid approximately $31 million. They were paid approximately $23 million. Now, the cost would have been somewhere in between those two numbers.

Medicaid's failure is reflected in the growing amount of uncompensated care, which takes the form of charity, bad debts, and those kinds of things provided by Montana hospitals. Uncompensated care in our hospitals in Montana amounted to $18 million in 1987. It was higher last year, and between 1980 and 1987, the

amount in total was roughly $114 million. Uncompensated care is not free care. Simply, the hospital, through whatever resources it has, as well as local taxpayers, other patients, insurance companies, must pay the cost of providing that care.

Care for the poor, the underinsured, the uninsured is a traditional social mission of Montana hospitals. It is a mission all of us have assumed enthusiastically. But rising costs and shrinking budgets are whittling away our ability to continue to perform this mission the way we would like to do. Too many hospitals are being forced to choose between sacrificing their social mission or their economic viability.

Like Medicaid, Medicare reimbursement rates have also failed to keep up with inflation. With our increasingly competitive society, business and industry and other traditional sources of paying for health care for the medically indigent find that they are no longer able to provide these funds. Many nonhospital providers have already decided they cannot continue to participate in an underfunded Medicaid Program. As this trend continues, hospitals like mine, an urban referral facility, will see their census swell with more emergency room patients who really should be going elsewhere.

Medicaid also fails to provide access to health care for rural families. In Montana, 14 percent of the rural population and about 11 percent of rural families have an income below the Federal poverty level. But Medicaid eligibility is linked to eligibility for Aid to Families With Dependent Children [AFDC], and because most poor rural families stay in their communities, many are left out of Medicaid and become part of Montana's medically indigent population. Ending the dependence on public funds for financing long-term care would enable Medicaid to return to its job of providing access to health care for the poor.

There are other reforms that should happen, as well. For example, Medicaid eligibility should be uncoupled from AFDC and income should become the eligibility criterion and the Federal poverty guidelines the standard. States should be required to provide a medically needy program with special spend down eligibility provisions for those whose incomes exceed the Medicaid eligibility level, but who have been impoverished by catastrophic medical bills. The working poor above the poverty line who are not insured should be allowed to buy into Medicaid for health care coverage.

With Medicare and Medicaid, Congress pledged to guarantee that every American had access to affordable health care. The Commission has an opportunity to make sure we fulfill that commitment now and in the future. And personally, as one who's long had a special admiration for Senator Pepper, especially during his years in the House of Representatives, I believe that it would be a fitting, permanent memorial to him. Thank you for the opportunity to present our views, and thank you for having this Commission hearing here in Montana.

[The prepared statement of Mr. Downer follows:]

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Statement by William J. Downer, Jr.
Chairman-Elect, Montana Hospital Association
before the
Bi-Partisan Commission on Comprehensive Health Care
June 28, 1989

Mr. Chairman, members of the Commission, my name is William J. Downer, Jr. I am the President of Columbus Hospital in Great Falls, Montana. And this year I am serving as Chairman-Elect of the Montana Hospital Association.

It is a pleasure to appear before you today and to present testimony on behalf of Montana's hospitals.

Health care policy in the United States has been rooted in the belief that quality health care should be provided for all citizens and that perceived failures of the private market should be corrected.

Our goal -- as an Association and my own as a hospital CEO -- has been to provide access to that health care to all Americans on a high quality, affordable basis.

Nearly 25 years ago, Congress took a revolutionary step toward fulfilling this goal when it created Medicare and Medicaid. Through these programs, two medically-disenfranchised groups -- the elderly and the poor -- were promised the same access to health care that millions of Americans already enjoyed.

However, despite the successes of these two programs, we are still far from realizing these goals. Today's hearing focuses on two areas where this challenge is greatest.

We believe that an underlying cause of the shortcomings in the provision of access to both medical care generally and long-term care specifically can be traced to the Medicaid program.

Medicaid was designed to guarantee that high quality health care was not just a privilege enjoyed by a segment of society. Medicaid was supposed to make sure that everyone -- regardless of ability to pay -- had access to health care.

But Medicaid has failed to fulfill this objective.

In 1975, 63 percent of low-income Americans were covered by Medicaid. By 1984, Medicaid covered less than 40 percent of the persons living below the federal poverty guideline.

The number of persons living below the federal poverty level has grown by more than 36 percent during that period.

Long-Term Care

Turning now to long-term care, the original framers of Medicaid never intended that the major source of payment for these services would come from Medicaid. But today it does.

Long-term care is currently, with limited exceptions, financed with the personal equity of those who receive such care. When their resources are exhausted, Medicaid takes over payment.

But this system is bankrupting elderly Americans, while making Medicaid the primary source of third-party long-term care funding.

The elderly poor now consume a disproportionate amount of the Medicaid dollar. Half of Medicaid's expenditures nationally are for long-term care.

Another 25 percent is used to purchase Medicare Part B coverage and supplemental coverage for services not provided by Medicare.

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In other words, the nonelderly poor are being squeezed out of Medicaid as it becomes the public supplemental insurance for Medicare.

We can no longer live with the current long-term care financing scheme as the elderly population increases at a rate far greater than for other segments of the population.

MHA believes the time has come for a comprehensive overhaul of the way long-term care is financed.

We need to devise a way to finance long-term care that does not force elderly Americans into poverty.

We need to develop a public/private insurance partnership to finance long-term care.

And we need to get Medicaid out of the business of financing long-term care and back into the business of providing access to health care for the poor.

In our view, there are several financing proposals that should be considered. Tax incentives could be used to encourage individuals and/or employers to finance long-term care insurance voluntarily.

Employers could be required to provide long-term care benefits to their employees. Or such benefits could be provided through an expansion of Medicare Part A or by creating a new Medicare Part C.

Each of these plans has merit, and each should be examined closely. America's population is graying and the demand for long-term care will continue to grow. Unless a comprehensive plan is developed soon, the next generation of elderly Americans face a grim future.

Health Care for the Medically Indigent

The elderly will not be the only losers, however.

Unless a comprehensive plan is developed soon, the next generation of poor mothers and children face a future that continues to close the doors of acess to America's health system.

In Montana, Medicaid's funding has shrunk dramatically in recent years. As a result, Medicaid reimbursements are falling farther and farther behind the cost of providing care.

In 1987, billings to Medicaid were $30,945,598 for all Montana hospitals. However, reimbursements to hospitals were $8,092,354 less than these charges. This gap continues to widen.

Medicaid's failure is reflected in the growing amount of uncompensated care provided by Montana's hospitals. In 1987, uncompensated care in our hospitals amounted to more than $18 million. Between1980 and 1984, that amount has reached almost $114 million. (See Table 1.)

Uncompensated care is not free care. Someone -- the hospital, local taxpayers, other patients, insurance companies -- must pay the costs of providing that care.

Care for the poor, the underinsured and the uninsured is a traditional social mission of Montana's community hospitals. It is a mission we have assumed enthusiastically.

But rising costs and shrinking budgets are whittling away our ability to perform this mission. Too many hospitals are being forced to choose between sacrificing their social mission or their economic viability.

Like Medicaid, Medicare reimbursement rates have failed to keep up with inflation.

In the last six years, there has been a 13 percent discrepancy between the inflation rate in the healthcare industry and increases in reimbursements.

Two years ago, Medicare paid Montana hospitals more than $34 million less than actual charges. This gap also has widened each year since.

Other traditional sources of paying for healthcare for the medically indigent find that they are no longer able to continue providing these funds.

Business and industry, confronted with their own competitive pressures, are refusing to underwrite uncompensated care by sanctioning cost-shifting.

Many non-hospital providers have already decided that they cannot continue to participate in an underfunded Medicaid program and dropped out. As this trend continues, hospitals like mine -- an urban referral facility -- will see their census swell with more intensely ill indigent patients.

The Rural Poor

Medicaid also fails to provide access to healthcare for rural families.

In Montana, 14 percent of the rural population and 11.1 percent of rural families have an income below the federal poverty level.(See .Table 2.)

But Medicaid eligibility is linked to eligibility for Aid to Families with Dependent Children, and because most poor rural families stay intact, many are left out of Medicaid and become part of Montana's medically indigent population.

Local government or hospitals are forced to carry the burden of financing health care for these families.

Medicaid Reform

There is no need to enact new programs to address the needs of the poor, the uninsured and the underinsured. However, existing programs must be adequately funded.

And the dependence on public funds for financing long-term care must be ended. This would enable Medicaid to return to its job of providing access to health care for the poor.

There are other reforms needed as well. For example, Medicaid should be decoupled from AFDC. Income should be the eligibility criterion and the federal poverty guidelines the standard.

States should be required to provide a medically needy program with special spend down eligibility provisions for those whose

incomes exceed the Medicaid eligibility level but who have been impoverished by catastrophic medical bills.

And the working poor above the poverty line who are not insured should be allowed to buy-in to Medicaid for health care coverage.

Conclusion

We in Montana are proud of the quality of health care we provide. But, like every part of America, Montana's healthcare industry is changing dramatically.

With Medicare and Medicaid, Congress pledged to guarantee that every American had access to affordable healthcare. The Commission has an opportunity to make sure we fulfill that commitment now and in the future.

Thank you for this opportunity to present our views. And thank you for taking the effort to travel to Montana to hear them.

Table 1

Year	Uncompensated Care
1980	$ 9,632,867
1981	9,162,810
1982	12,949,682
1983	16,337,878
1984	15,945,770
1985	15,085,242
1986	16,696,144
1987	18,058,304
Total	$113,868,697

Table 2

	State	Urban	Rural	Farm Rural
Individuals	94,280	43,006	51,274	11,753
	12.3%	10.7%	14%	20.2%
Families	19,019	7,864	11,155	2,768
	9.2%	7.4%	11.1%	16.7%

Source: U.S. Census 1980.

Chairman BAUCUS. Thank you very much, Bill. Before I proceed, I want to introduce, for members of the audience, the other members of the panel. First, Al Cain. Alan is president of Blue Cross-Blue Shield in the State of Montana. In addition, we have Rose Hughes, who is the executive director of the Montana Health Care Association. Also, Kay Jennings, director of Home Health Care and Nursing Home in Sidney; is that correct?

Ms. JENNINGS. Director of Medicare Certified Home Health Agency and Medicaid Waiver Program.

Chairman BAUCUS. OK. I got that straight. And also Mr. Wheeler, David Wheeler. He is representing the Montana Nurses Association.

Mr. WHEELER. Not exactly, but we'll let it stand for now.

Chairman BAUCUS. You can correct all this when you testify. Go first with Alan.

STATEMENT OF ALAN CAIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BLUE CROSS/BLUE SHIELD OF MONTANA

Mr. CAIN. Thank you, Senator. I'm Alan F. Cain, president and chief executive officer of Blue Cross and Blue Shield of Montana. Blue Cross and Blue Shield is a nonprofit health service corporation and the largest private insurer of health care services in Montana. In 1988 we had premium income of $141.8 million and paid $134.5 million in claims for the health care services of over 215,000 Montanans. We also administer the Medicare Part A and Part B contracts in Montana, and in fiscal year 1988 we processed 221,000 Part A claims for $157.6 million and 1 million Part B claims amounting to $55.4 million.

We appreciate the opportunity to address you today on a concern of ours in Montana and a concern of all the 74 independent Blue Cross and Blue Shield plans which make up the Blue Cross and Blue Shield system. The constantly rising costs of health care have played a significant role in people's ability to purchase health care coverage from us or from our competitors. As you indicated earlier, Senator, it's estimated now that 37 million people in this country who are not eligible for Medicare or Medicaid do not have health insurance of any type. And I might add that the actuaries are now beginning to trend that figure because it's increasing.

In an effort to find ways to help those who are currently uninsured secure health insurance, the Blue Cross and Blue Shield Association recently commissioned the Gallup organization to conduct a research project for us in Montana and three other areas of the country to better understand the reasons why people, and particularly small businesses, either don't purchase health care coverage for their employees or have chosen to drop the coverage they once had.

I'll share some of that information with you in just a moment, but before doing that, I would like to highlight for you and the Commission some of the statistics in terms of cost and utilization trends that we have to look at every day when we do our underwriting. It has not been what you would call a pretty picture, but we do have some hope that with a major effort on cost-saving pro-

grams and some constraints by everyone concerned, the picture will get better.

We use several key indicators when projecting the premiums necessary to pay the bills of those we cover. These indicators reflect both the change in unit costs and the number of services performed. Since 1987, these key indicators have reflected an overall double-digit increase in the cost of medical care while the general Consumer Price Index has had rather modest increases during the same time. The examples that I've chosen to use are these: The cost of inpatient hospital cases between 1986 and 1987, they rose 14 percent, from 1987 to 1988, 20 percent, and we would estimate that those costs would increase 23 percent in 1989. For outpatient hospital claims they rose 28 percent from 1986 to 1987, 31 percent from 1987 to 1988, and we estimate that this year it will moderate some, but still raise 15 percent. In the area of professional services, from 1986 to 1987, those were up 15 percent, 1987 to 1988 up 16 percent, and we'll estimate they'll rise another 10 percent this year. I'll try to put those changes, as well as the other changes we observed, into perspective as they affect premiums and claim payments which we experience.

If the people we have covered maintain their current type of coverage, we will need an additional $27 million this year to pay for the increased costs of providing medical care to them. The factors driving this increase in costs are, and this isn't an exhaustive list, but it's the major ones. First, the failure of Medicaid and Medicare to pay for the full cost of care delivered to those populations with the resulting shift of costs to the private sector. Second, increasing availability and use of expensive technology, such as MRI's [magnetic resonance imaging], CAT [computerized axial tomography] scans, and the like. I would hasten to say that in mentioning these, I am not being critical of these sources of care, I'm simply pointing out that they are expensive. Third, increasing numbers of services being performed. We believe this is a function of the numbers of physicians, patient demand, and physician reaction to the malpractice environment, which Dr. Coombs mentioned earlier. Fourth, State-mandated benefits which force insurers to cover types of care which have not usually been included in health insurance policies in the past. And fifth, very expensive therapies and types of care which were not available in previous years which generate costs in the nature of hundreds of thousands of dollars for individual cases. An example would be neonatal cases and major organ transplants.

The net of all this is many people cannot afford health care premiums, so they drop their coverage. The research we conducted in Montana last winter has given us some information concerning this question and gives us some new ideas about bringing these folks back to an insured status.

Our studies show that 42 percent of small groups with 3 to 24 employees are uninsured. And I should mention that the bulk of the employers in Montana are in this category.

Chairman BAUCUS. What's that figure again?

Mr. CAIN. Forty-two percent of small groups with enrollments of 3 to 24 employees. However, 88 percent of the small group decisionmakers or owners have purchased an individual policy for themselves. We learned in this survey that 55 percent of the uninsured

small groups were either in restaurants, bars, personal services, or retail/wholesale trade. Of small groups surveyed, 41 percent reported the reason they do not purchase health insurance is because the premium is more than they can afford. Another 11 percent said they do not purchase health insurance because of the type of employees in their work force. For example, the employees are seasonal or temporary. They cited high turnover or the fact that they do not need to offer insurance to attract employees. Another 32 percent reported the reason for not purchasing health insurance through the business is because they believe their employees are covered through other sources, such as a spouse who has insurance through his or her place of employment.

The important point is that high cost is an extremely significant factor preventing small businesses from providing coverage. A couple of examples will illustrate the magnitude of current costs for small groups in Montana. First, I'd like to mention, a small group in an eastern Montana city, it's Red Lodge. The employer contribution for coverage in that group is $20 per month. The premium for a single person in this group of eight is $109.44 a month, for two people it's $218.88, and for a family it's $300.96. These premiums are actuarially calculated based on the cost of the health care services used by the group in the past and what we anticipate those costs to be in the future. Six people are paying those rates today, but we've heard from two employees who said the costs are more than they can afford, and we assume those two people are currently uninsured.

The second group has 26 covered employees in a small northeastern Montana town. The rates for this group are $165.53 for a single, $327.16 for two people, and $449.84 for a family. The employer pays the single rate of $165 in this case, but a family still would have to contribute $286 a month. A severe burden in an area where wages are not high to begin with.

I'd like to close my testimony today, Senator, with a few suggestions as to ways this situation can be improved or not worsened. First, we can all do a better job of trying to manage the health care services for those people who need medical care. It's our belief that one of the principal ways we can impact these costs is to try to see that care is not delivered when it's not needed or in situations which deliver more care than is required under the circumstances. We have established the only health maintenance organization in Montana, and although it is in its infancy, it's proven to be cost effective in providing high quality care. Having listened to Dr. Coombs earlier today, the family practitioners in Montana were particularly helpful to us in moving that project forward. We are hopeful we can interest more providers of care in working with us to make this program available to more people. Second, we have expanded our own managed care program of Blue Cross-Blue Shield. Through this, with registered nurses and physicians who are staffed to us, we work with doctors and hospitals to try to ensure that necessary care is delivered in the least costly setting appropriate for the patient's condition. Although these types of programs are somewhat onerous for the providers, and we understand that, we can tell you in a very short time, since last Novem-

ber, we have averted over a half million dollars in hospital costs through this program.

At the national level we would recommend three legislative changes which would improve private sector coverage of the uninsured Americans. Of course, we recommend that ERISA [Federal Employee Retirement Income Security Act] be amended so small employers purchasing health insurance will not have to include State-mandated benefits. States have enacted over 700 separate laws requiring all insurers to cover certain benefits as part of their minimum packages. These mandated benefits have, according to some research, increased premiums as much as 20 percent in some States. Companies that self-insure their employee health benefits, generally large companies, are exempt from these State mandates under ERISA, while companies that purchase insurance must include these benefits. Amending ERISA to exempt private insurers from State-mandated benefits would allow them to design lower cost benefit packages tailored to the needs of small and marginally profitable employers.

Second, give the self-employed the same tax incentives for purchase of health insurance benefits given to large corporations. Large corporations can deduct 100 percent of their cost of providing health benefits to employers. However, the self-employed currently can deduct only 25 percent of such expenses, and this deduction will be eliminated in 1990.

Third, encourage State risk pools where needed by including self-funded companies within the financing mechanism. Risk pools can be a valuable source of help in providing a way for individuals with serious health problems to purchase insurance at affordable rates. Our company acts as the administrator for the risk pool in the State of Montana. Risk pools are usually subsidized by an assessment on insurance companies, but self-insured companies are exempt from participating in this type of State requirement under ERISA. We believe that ERISA should be amended to provide States the authority to assess self-funded companies as well as insurers for the shortfall in funding that will always be generated by a high-risk pool.

On behalf of the Blue Cross-Blue Shield, I appreciate the opportunity to appear here, and I thank you, also, for having one of your hearings of this Commission in Montana.

[The prepared statement of Mr. Cain follows:]

TESTIMONY

BY

ALAN F. CAIN

PRESIDENT AND CHIEF EXECUTIVE OFFICER

OF

BLUE CROSS AND BLUE SHIELD OF MONTANA

BEFORE THE

PEPPER COMMISSION

MISSOULA, MONTANA

JUNE 28, 1989

MR. CHAIRMAN AND STAFF OF THE PEPPER COMMISSION, I AM ALAN F. CAIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER OF BLUE CROSS AND BLUE SHIELD OF MONTANA.

BLUE CROSS AND BLUE SHIELD OF MONTANA IS A NONPROFIT HEALTH SERVICE CORPORATION AND THE LARGEST PRIVATE INSURER OF HEALTH CARE SERVICES IN MONTANA. IN 1988, WE HAD PREMIUM INCOME OF $141.8 MILLION AND WE PAID $134.5 MILLION IN CLAIMS FOR THE HEALTH CARE SERVICES OF OVER 215,000 MONTANANS.

WE ALSO ADMINISTER THE MEDICARE PART A AND PART B CONTRACTS IN MONTANA, AND IN FISCAL YEAR 1988 WE PROCESSED 221,000 PART A CLAIMS TOTALLING $157.6 MILLION AND ONE MILLION PART B CLAIMS AMOUNTING TO $55.4 MILLION.

WE APPRECIATE THE OPPORTUNITY TO ADDRESS THIS BODY TODAY ON A CONCERN OF OURS IN MONTANA AND A CONCERN OF ALL OF THE 74 INDEPENDENT BLUE CROSS AND BLUE SHIELD PLANS WHICH MAKE UP THE BLUE

CROSS AND BLUE SHIELD SYSTEM. THE CONSTANTLY RISING COSTS OF HEALTH CARE HAVE PLAYED A SIGNIFICANT ROLE IN PEOPLE'S ABILITY TO PURCHASE HEALTH CARE COVERAGE FROM US OR FROM OUR COMPETITION. IT IS ESTIMATED THAT 37 MILLION PEOPLE IN THIS COUNTRY, WHO ARE NOT ELIGIBLE FOR MEDICAID OR MEDICARE, DO NOT HAVE HEALTH INSURANCE.

IN AN EFFORT TO FIND WAYS TO HELP THOSE WHO ARE CURRENTLY UNINSURED SECURE HEALTH INSURANCE, THE BLUE CROSS AND BLUE SHIELD ASSOCIATION RECENTLY COMMISSIONED THE GALLUP ORGANIZATION TO CONDUCT A RESEARCH PROJECT FOR US IN MONTANA AND THREE OTHER AREAS OF THE COUNTRY TO BETTER UNDERSTAND THE REASONS WHY PEOPLE, AND PARTICULARLY SMALL BUSINESSES, EITHER DON'T PURCHASE HEALTH CARE COVERAGE FOR THEIR EMPLOYEES, OR HAVE CHOSEN TO DROP THE COVERAGE THEY ONCE HAD.

I WILL SHARE SOME OF THAT INFORMATION WITH YOU IN JUST A MOMENT, BUT BEFORE DOING THAT I WOULD LIKE TO HIGHLIGHT FOR THE COMMIS-

SION SOME OF THE STATISTICS, IN TERMS OF COST AND UTILIZATION TRENDS, THAT WE LOOK AT EVERY DAY WHEN WE DO OUR UNDERWRITING. IT HAS NOT BEEN WHAT YOU WOULD CALL A PRETTY PICTURE, BUT WE ARE HOPEFUL THAT WITH A MAJOR EFFORT ON COST SAVING PROGRAMS AND SOME CONSTRAINTS BY ALL CONCERNED, THE PICTURE WILL GET BETTER.

WE USE SEVERAL KEY INDICATORS WHEN PROJECTING THE PREMIUMS NECESSARY TO PAY THE BILLS OF THOSE WE COVER. THESE INDICATORS REFLECT BOTH THE CHANGE IN UNIT COSTS AND THE NUMBER OF SERVICES PREFORMED. SINCE 1987, THESE KEY INDICATORS HAVE REFLECTED AN OVERALL DOUBLE DIGIT INCREASE IN THE COST OF MEDICAL CARE WHILE THE GENERAL CPI HAS HAD RATHER MODEST INCREASES:

COST OF INPATIENT HOSPITAL CASES

1986-1987 + 14%

1987-1988 + 20%

1988-1989 + 23% - ESTIMATED

COST OF OUTPATIENT HOSPITAL CLAIMS

1986-1987 + 28%

1987-1988 + 31%

1988-1989 + 15% - ESTIMATED

COST OF PROFESSIONAL SERVICES

1986-1987 + 15%

1987-1988 + 16%

1988-1989 + 10% - ESTIMATED

I'LL TRY TO PUT THESE CHANGES, AS WELL AS OTHER CHANGES WE OBSERVED, INTO PROSPECTIVE AS THEY AFFECT PREMIUMS AND CLAIM PAYMENTS.

IF THE PEOPLE WE HAVE COVERED MAINTAIN THEIR CURRENT TYPE OF COVERAGE, WE WILL NEED AN ADDITIONAL $27 MILLION THIS YEAR TO PAY FOR THE INCREASED COSTS OF PROVIDING MEDICAL CARE TO THEM.

THE FACTORS DRIVING THIS INCREASE IN COSTS ARE:

1. FAILURE OF MEDICAID AND MEDICARE TO PAY FOR THE FULL COST OF CARE DELIVERED TO THOSE POPULATIONS WITH THE RESULTING SHIFT OF COSTS TO THE PRIVATE SECTOR.

2. INCREASING AVAILABILITY AND USE OF EXPENSIVE TECHNOLOGY SUCH AS MRIS.

3. INCREASING NUMBERS OF SERVICES BEING PERFORMED. THIS IS A FUNCTION OF THE NUMBERS OF PHYSICIANS, PATIENT DEMAND AND PHYSICIAN REACTION TO THE MALPRACTICE ENVIRONMENT.

4. STATE MANDATED BENEFITS WHICH FORCE INSURERS TO COVER TYPES OF CARE NOT USUALLY INCLUDED IN HEALTH INSURANCE POLICIES IN THE PAST.

5. VERY EXPENSIVE THERAPIES AND TYPES OF CARE NOT AVAILABLE IN PREVIOUS YEARS WHICH GENERATE COSTS IN THE HUNDREDS OF THOUSANDS OF DOLLARS. EXAMPLES WOULD BE NEONATAL CASES AND MAJOR ORGAN TRANSPLANTS.

THE NET OF ALL THIS IS THAT PEOPLE CANNOT AFFORD HEALTH INSURANCE PREMIUMS, SO THEY DROP THEIR HEALTH COVERAGE. THE RESEARCH WE CONDUCTED IN MONTANA LAST WINTER HAS GIVEN US SOME INFORMATION CONCERNING THIS AND GIVES US NEW IDEAS ABOUT BRINGING THESE FOLKS BACK INTO AN INSURED STATUS.

OUR STUDY SHOWED THAT FORTY-TWO PERCENT OF SMALL GROUPS WITH 3 TO 24 EMPLOYEES IN MONTANA ARE UNINSURED. HOWEVER, 88 PERCENT OF THE SMALL GROUP DECISION-MAKERS OR OWNERS HAVE PURCHASED AN INDIVIDUAL POLICY FOR THEMSELVES.

WE LEARNED IN THIS SURVEY THAT 55 PERCENT OF THE UNINSURED SMALL GROUPS WERE EITHER IN RESTAURANTS/BARS/PERSONAL SERVICES OR THE

RETAIL/WHOLESALE TRADE. FORTY-ONE PERCENT OF SMALL GROUPS SURVEYED REPORTED THE REASON THEY DO NOT PURCHASE HEALTH INSURANCE IS BECAUSE THE PREMIUM IS MORE THAN THEY CAN AFFORD. ANOTHER 11 PERCENT SAID THEY DO NOT PURCHASE HEALTH INSURANCE BECAUSE OF THE TYPE OF EMPLOYEES IN THEIR WORK FORCE, E.G., SEASONAL OR TEMPORARY. THEY CITED HIGH TURNOVER OR THE FACT THAT THEY DO NOT NEED TO OFFER INSURANCE TO ATTRACT EMPLOYEES. ANOTHER 32 PERCENT REPORTED THE REASON FOR NOT PURCHASING HEALTH INSURANCE IS BECAUSE THEY BELIEVE THEIR EMPLOYEES ARE COVERED THROUGH OTHER SOURCES, SUCH AS A SPOUSE WHO HAS INSURANCE THROUGH HIS OR HER PLACE OF EMPLOYMENT.

THE IMPORTANT POINT IS THAT HIGH COST IS A SIGNIFICANT FACTOR PREVENTING SMALL BUSINESSES FROM PROVIDING COVERAGE.

A COUPLE OF EXAMPLES WILL ILLUSTRATE THE MAGNITUDE OF CURRENT COSTS FOR SMALL GROUPS IN MONTANA.

FIRST, IN A SMALL EASTERN MONTANA CITY (RED LODGE), THE EMPLOYER CONTRIBUTION FOR COVERAGE IS $20 PER MONTH. THE PREMIUM FOR A SINGLE PERSON IN THIS GROUP OF EIGHT IS $109.44 PER MONTH. FOR TWO PEOPLE IT'S $218.88, AND FOR A FAMILY $300.96. THESE PREMIUMS ARE BASED ON COST OF THE HEALTH CARE SERVICES USED BY THE GROUP IN THE PAST AND WHAT WE ANTICIPATE THOSE COSTS WILL BE IN THE FUTURE. SIX PEOPLE ARE PAYING THESE RATES BUT WE HEARD FROM TWO EMPLOYEES WHO SAID THE COSTS WERE MORE THAN THEY COULD AFFORD.

THE SECOND GROUP HAS 26 COVERED EMPLOYEES IN A SMALL NORTHEASTERN MONTANA TOWN. THEIR RATES ARE $165.53 FOR A SINGLE; $327.16 FOR TWO PERSON, AND $449.84 FOR A FAMILY. THE EMPLOYER PAYS THE SINGLE RATE OF $165, SO A FAMILY WOULD HAVE TO CONTRIBUTE $286.26 A MONTH -- A SEVERE BURDEN IN AN AREA WHERE WAGES ARE NOT HIGH TO BEGIN WITH. I WOULD LIKE TO CLOSE MY TESTIMONY TODAY WITH A FEW SUGGESTIONS AS TO WAYS THIS SITUATION CAN BE IMPROVED.

FIRST, WE CAN ALL DO A BETTER JOB AT TRYING TO MANAGE THE HEALTH CARE SERVICES FOR THOSE PEOPLE WHO NEED MEDICAL CARE. WE HAVE ESTABLISHED THE ONLY HEALTH MAINTENANCE ORGANIZATION IN MONTANA, AND ALTHOUGH IT IS IN ITS INFANCY, IT HAS PROVEN TO BE COST EFFECTIVE IN PROVIDING HIGH QUALITY CARE. WE ARE HOPEFUL WE CAN INTEREST MORE PROVIDERS OF CARE IN WORKING WITH US TO MAKE THIS PROGRAM AVAILABLE TO MORE PEOPLE.

SECOND, WE HAVE EXPANDED OUR MANAGED CARE PROGRAM. WE WORK WITH DOCTORS AND HOSPITALS TO TRY TO ENSURE THAT NECESSARY CARE IS DELIVERED IN THE LEAST COSTLY SETTING APPROPRIATE FOR THE PATIENT'S CONDITION. IN A VERY SHORT TIME WE HAVE AVERTED OVER HALF A MILLION DOLLARS IN HOSPITAL COSTS THROUGH THIS PROGRAM.

AT THE NATIONAL LEVEL, WE WOULD RECOMMEND THREE LEGISLATIVE CHANGES WHICH WILL IMPROVE PRIVATE SECTOR COVERAGE OF UNINSURED AMERICANS:

1. AMEND ERISA SO THAT SMALL EMPLOYERS PURCHASING HEALTH INSURANCE WILL NOT HAVE TO INCLUDE STATE-MANDATED BENEFITS.

STATES HAVE ENACTED OVER 700 SEPARATE LAWS REQUIRING ALL INSURERS TO COVER CERTAIN BENEFITS AS PART OF THEIR MINIMUM PACKAGES. THESE "MANDATED BENEFITS" HAVE INCREASED PREMIUMS BY 20 PERCENT IN SOME STATES. COMPANIES THAT SELF-INSURE THEIR EMPLOYEE HEALTH BENEFITS (GENERALLY LARGE COMPANIES) ARE EXEMPT FROM THESE STATE MANDATES UNDER ERISA WHILE COMPANIES THAT PURCHASE INSURANCE MUST INCLUDE THESE BENEFITS.

AMENDING ERISA TO EXEMPT PRIVATE INSURERS FROM STATE-MANDATED BENEFITS WOULD ALLOW THEM TO DESIGN LOWER COST BENEFIT PACKAGES TAILORED TO THE NEEDS OF SMALL AND MARGINALLY PROFITABLE EMPLOYERS.

2. GIVE THE SELF-EMPLOYED THE SAME TAX INCENTIVES FOR PURCHASE OF HEALTH INSURANCE BENEFITS GIVEN TO LARGE CORPORATIONS.

LARGE CORPORATIONS CAN DEDUCT 100 PERCENT OF THEIR COST OF PROVIDING HEALTH BENEFITS TO EMPLOYEES. HOWEVER, THE SELF-EMPLOYED CURRENTLY CAN DEDUCT ONLY 25 PERCENT OF SUCH EXPENSES, AND THIS DEDUCTION WILL BE ELIMINATED IN 1990.

3. ENCOURAGE STATE RISK POOLS WHERE NEEDED BY INCLUDING SELF-FUNDED COMPANIES WITHIN THE FINANCING MECHANISM.

RISK POOLS CAN BE VALUABLE IN PROVIDING A WAY FOR INDIVIDUALS WITH SERIOUS HEALTH PROBLEMS TO PURCHASE INSURANCE AT AFFORDABLE RATES. OUR COMPANY ACTS AS THE ADMINISTRATOR FOR THE RISK POOL IN MONTANA.

RISK POOLS ARE USUALLY SUBSIDIZED BY AN ASSESSMENT ON INSURANCE COMPANIES, BUT SELF-INSURED COMPANIES ARE EXEMPT FROM PARTICIPATING IN THIS TYPE OF STATE REQUIREMENT UNDER ERISA. WE BELIEVE THAT ERISA SHOULD BE AMENDED TO PROVIDE STATES THE AUTHORITY TO ASSESS SELF-FUNDED COMPANIES AS WELL AS INSURERS FOR THE SHORT-FALL IN FUNDING THAT WILL ALWAYS BE GENERATED BY A HIGH-RISK POOL.

ON BEHALF OF BLUE CROSS AND BLUE SHIELD OF MONTANA, I APPRECIATE HAVING BEEN GIVEN THE OPPORTUNITY TO APPEAR BEFORE YOU HERE TODAY.

THANK YOU.

AFC/SKS
D261K

Chairman BAUCUS. Thank you very much. It was a very interesting and provocative statement. Rose.

STATEMENT OF ROSE HUGHES, EXECUTIVE DIRECTOR, MONTANA HEALTH CARE ASSOCIATION

Ms. HUGHES. Thank you. For the record, I'm Rose Hughes, executive director of the Montana Health Care Association, an association that represents 80 of Montana's 97 long-term care facilities. Our facilities range in size from 13 to 232 licensed beds and are located in communities ranging from 600 to 70,000 people. The road-miles between our northwesternmost facility at Libby and our southeasternmost facility at Ekalaka is over 700 miles, a distance equivalent to traveling from Washington, DC, to the northernmost tip of Maine.

If I had to convey to you the single most pressing problem facing Montana's long-term care facilities today, that problem would be Government regulation; laws and regulations that our facilities are required to comply with whether or not they make sense and whether or not they improve patient care. Running a very close second would be inadequate reimbursement by the State and Federal Medicaid and Medicare Programs. All too often in Montana we find that what seemed like a good idea to people in Washington, DC, simply doesn't work here. We find ourselves coping with impossible solutions to problems we don't have, and with no solutions to problems we do have. What plays in New York, California, and Texas, does not necessarily play in Montana.

The Nursing Home Reform Provisions of the Omnibus Budget Reconciliation Act in 1987, or OBRA, has become a household word in our facilities. It has also become a source of frustration and concern for our owners, administrators, and our staff. There is no doubt that the law was well-intentioned. However, in looking at the reality of implementing the law, it becomes apparent that it places some unrealistic expectations on facilities, staff, and the States. And it fails to take into account the differences among the States in terms of geography, financial, and human resources, and the types and quality of services available.

Let's take nurse aide training. Consumers, providers, and regulators agree that better-trained nurse aides will provide better patient care. However, the OBRA statute and the proposed implementing regulations don't stop after mandating more and better training for our nurse aides. They go on to prescribe how that training is to be accomplished. An example is competency evaluation. The law mandated that nurse aides complete training and competency evaluation programs. This has been interpreted to mean that all nurse aides trained in facilities must be competency evaluated by the State based on both a written and a skills test. It is still unclear how the skills test will be done. What is clear is that at least some people in Washington believe that our nursing homes are not capable of determining the clinical competency of our nurse aides. In Montana, that could mean either the State sending people to facilities, which can be as far apart as 700 miles, to watch nurse aides make a bed or feed a patient or having our nurse aides travel hundreds of miles to be tested in these very

basic skills. At best, this is unnecessary and costly. At worst, given winter driving conditions in Montana, it can even be dangerous. Having State policemen traveling all over a State this size to watch nurse aides make beds or asking nurse aides to travel hundreds of miles to test sites, spending hours that could be much better spent in the facility taking care of patients, doesn't make sense. It's not a good way to use limited health care dollars and personnel, and it will hurt, not help, our patients.

The State of Montana has developed a proposal to accomplish this testing that avoids extensive traveling by either the State or the nurse aides. Our main concern at this point is that every indication is that the Federal Government at some point will force us to abandon this sensible approach for another that is not suited to our State.

Another example is in the area of staff and consultants. OBRA's provision that all facilities must meet skilled standards must mean all our facilities must employ certain staff and consultants—staff and consultants which may not be readily available in our rural communities. Even current staffing in some disciplines is accomplished with great difficulty, requires considerable traveling and great expense.

The specific requirement of a full-time bachelor's degree social worker in facilities of over 120 beds is also troubling. An administrator in Miles City described the impact of this requirement on his facility in a letter that reads in part: "We have a full-time social services designee in our facility on staff and a licensed social worker as a consultant part time. We have never had a deficiency in our social services area. This indicates that the needs of our residents are being met properly with the system we have implemented. Our ability to hire a social service worker with a bachelor's degree in eastern Montana will be very difficult." He goes on to say that his current employee, who does a good job, will have to be fired and someone with a bachelor's degree hired unless there is some waiver or grandfathering of this current employee. He concludes: "To dismiss an employee who has a track record to hire another at a considerably higher wage scale because of educational credentials and no track record, seems to me to be the height of folly." I think you'll agree with that.

I'm sure that preadmission screening for MI/MR [mentally ill/mentally retarded] patients, for all nursing home patients also sounded like a good idea when it was adopted in Washington. However, it is causing some problems in Montana. In our rural areas, those hired by the State to perform the screening cover a very wide geographic area. Thus, when a patient needs to be screened, there is not always someone available to do the screening and admissions are being delayed. Also, in one instance that I was recently informed of, a patient who had been in the local nursing home in Poplar, a community of about 900 people in northeastern Montana, for over 14 years, went home on a trial basis. It did not work out, unfortunately, and after a short time the patient sought readmission to the facility. Unfortunately, the readmission was sought after the new preadmission screening requirements went into effect. This patient was not allowed to return to the facility. There is no other placement for this woman locally, and she will likely be

moved to a location where other services are available to her. She will be forced to leave her community, family, and the facility that was her home for 14 years, all because Congress passed a law; a law that might work in some places where alternatives are more readily available, but not a community of 900 in northeastern Montana.

Montana's long-term care facilities are attempting to cope with all of these new requirements. Of great frustration to us as we do this are the mixed signals coming out of Washington. As providers, we have pushed our State agencies for information and instructions on implementation of OBRA, only to be told that they were waiting for the Health Care Financing Administration in Washington to provide regulations. That Administration has missed every implementation deadline contained in the Federal law, and so have the State agencies. Congress has somewhat condoned this by including a provision in the law that requires facilities and States to comply with the law even if the Federal Government doesn't. It's an untenable situation and the providers are caught in the middle.

In addition to all of this, funds to pay for the care we provide are becoming more and more limited. Long-term care facilities are being asked to care for sicker patients, to increase staff and services despite a shortage of licensed nurses, to do more and more paperwork to document the care being given, and to do it all with inadequate funds and without flexibility to accomplish tasks in the most cost-effective ways.

Our ability to meet the needs of our patients will depend on a combination of things, the most important of which are adequate funding, and a regulatory arena that allows maximum flexibility to States and facilities to find solutions and reach goals in ways that are both economic and fruitful in terms of leading to high quality services for our patients.

Providing long-term care services in Montana is more difficult than in States where there are larger concentrations of people and smaller geographic areas to cover, but we're accustomed to the challenge of living where we live. We've learned to work together to find creative solutions to problems and to attain good results with fewer resources than others have available. That is why it's so important that the solutions found in Washington for problems relating to the financing and quality of long-term health care take into account the unique characteristics of a State like ours. We must be allowed to apply Montana solutions to our health care problems. I appreciate the opportunity to present our views today, and I'd be happy to answer questions.

[The prepared statement of Ms. Hughes follows:]

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TESTIMONY OF ROSE M. HUGHES,

EXECUTIVE DIRECTOR, OF THE MONTANA HEALTH CARE ASSOCIATION

before the

BI-PARTISAN COMMISSION ON LONG TERM CARE

Hearing: June 28, 1989
Missoula, Montana

An Affiliate of
ahca
American Health Care Association

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TESTIMONY OF ROSE M. HUGHES, EXECUTIVE DIRECTOR,
MONTANA HEALTH CARE ASSOCIATION

EXHIBIT 1. Cost Projections: Montana Implementation of the Omnibus Budget Reconciliation Act of 1987, Executive Summary.

EXHIBIT 2. Article from April 1989 issue of Provider, entitled "Policy Perspective: Care at No Direct Cost to Recipients? It Can't Be Done."

EXHIBIT 3. Issue Papers prepared by the American Health Care Association and concurred in by the Montana Health Care Association.

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For the record, I am Rose Hughes, Executive Director of the Montana Health care Association, an association representing 80 of Montana's 97 long term care facilities. Our facilities range in size from 13 to 232 licensed beds, and are located in communities ranging from 600 to 70,000 people. The road miles between our northwestern most facility at Libby and our southeastern most facility at Ekalaka is over 700 miles--a distance equivalent to travelling from Washington, D.C. to the northernmost tip of Maine.

On Behalf of our member facilities, I wish to thank you for the opportunity to be here today to address the issues facing Montana's long term care facilities.

If I had to convey to you the single most pressing problem facing Montana's long term care facilities today, that problem would be GOVERNMENT REGULATION--laws and regulations that our facilities are required to comply with whether or not they make sense, and whether or not they improve patient care. Running a very close second, would be inadequate reimbursement by the state and federal Medicaid and Medicare programs. Combined, government regulation and inadequate reimbursement--team up to create serious hardships for our facilities and divert time and energy away from our job, which is to provide high quality care to our patients.

All too often we in Montana find that what seemed like a good idea to people in Washington, D.C., simply does not work here in Montana. We find ourselves coping with impossible

solutions to problems we don't have, and with no solutions to problems we do have. What plays in New York, California, and Texas does not necessarily play in Montana.

The Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987, or OBRA, has become a household word in our facilities. It has also become a source of frustration and concern for our owners, administrators, and staff. There is no doubt that the law was well-intentioned. However, in looking at the reality of implementing the law, it becomes apparent that it places some unrealistic expectations on facilities, staff, and the states. And, it fails to take into account the differences among the states in terms of geography, financial and human resources, and the types and quality of services available.

Let's take nurse aide training. Consumers, providers, and regulators agree that better-trained nurse aides are likely to result in better patient care. However, the OBRA statute, and the proposed implementing regulations, don't stop after mandating more and better training for our nurse aides. They go on to prescribe <u>how</u> that "training" is to be accomplished. And, the <u>how</u> is the same in Montana as it is in New York, California, and Texas. An example is "competency evaluation." The law mandated that nurse aides complete "training and competency evaluation" programs and that the state "determine competency" of nurse aides trained in facilities. This has been interpreted to mean that all nurse aides trained in facilities must be competency evaluated by the state based on both a written and "skills" test.

It is still unclear how the skills testing will be done. What is clear, is that at least some people in Washington believe that our nursing homes are not capable of determining the clinical competency of our nurse aides. And, in Montana, that could mean either the state sending people to facilities which can be as far apart as 700 miles to watch nurse aides make a bed or feed a patient; or, nurse aides traveling hundreds of miles to be tested in these basic skills. At best, this is unnecessary and costly. At worst, given winter driving conditions in Montana, it can even be dangerous.

And, why would we be doing all of this? Because some people in Washington don't trust our Directors of Nursing, licensed professionals who have chosen a career in long term care, and who are entrusted with the care of our mothers and grandmothers in our facilities, ...some people don't trust these people to watch nurse aides demonstrate certain basic skills and report to the State Health Department on the successful or unsuccessful performance of those skills. Having state "policemen" traveling all over a state this size to watch nurse aides make beds, or asking nurse aides to travel hundreds of miles to test sites (spending hours that could be better spent caring for patients in our facilities) does not make sense. It is not a good way to use limited health care dollars and personnel, and it will hurt, not help, our patients.

I should add that the State of Montana has developed a proposal to accomplish this testing which will <u>not</u> require

extensive travel by either the state or the nurse aides. It is a proposal that is both cost effective and reasonable in light of circumstances, resources and distances associated with carrying out such a project in a state like Montana. Our only concern is that it appears that the federal government may ultimately force us to abandon this sensible approach for another that is not suited to Montana.

Another example is in the area of staff and consultants. OBRA's provision that all facilities must meet skilled standards means that all of our facilities will have to employ certain staff and consultants--staff and consultants that may not be readily available in our rural communities. While we have few ICF-only facilities, the ones we do have are in small, rural communities. Licensed social workers, pharmacists, and dietitians are not available in many of these communities. Even current staffing of these disciplines is accomplished with difficulty and requires considerable travel.

And, the specific requirement for a full-time bachelor's degree social worker in facilities of over 120 beds could be particularly troublesome to our facilities. An administrator in Miles City, a community of about 9,500 people in southeastern Montana, described the impact of this requirement on his 121 bed facility in a letter that reads in part:

> "We have a full-time social services designees in our facility on staff, plus a licensed social worker as a consultant on a part-time basis. ...we have never had a deficiency in our social services area. ...This indicates that the needs of our residents are being met properly with the system that we have implemented. Our ability to hire a

> social service worker with a bachelor's degree in eastern Montana will be very difficult. I believe that there should be some mechanism for grandfathering of social services designees that have this kind of history and proof of performance."

He goes on to say that his current employee who is doing a good job will have to be fired and someone with a bachelor's degree hired unless there is some waiver or grandfathering of his current employee. He concludes:

> "...To dismiss an employee who has a track record to hire another at a considerably higher wage scale because of educational credentials with no track record seems to me to be the height of folly."

I think you'll agree with him.

I'm sure that pre-admission screening (MI/MR screening) of all nursing home patients also sounded like a good idea in Washington. However, it is causing problems in Montana. In our rural areas, those hired by the state to perform the screening cover a wide geographic area. Thus, when a patient needs to be screened, there is not always someone available to do the screening and admissions are being delayed, or facilities are risking admitting these patients prior to the state-approved screening being performed. Also, in one instance that I was recently informed of, a patient who had been in the local nursing home in Poplar, a community of about 900 people in northeastern Montana, for over 14 years, went home to live with her mother on a trial basis, to see if she could get along at home with help. It did not work out, and after a short time the patient sought readmission to the facility. Unfortunately, the readmission was sought after the new preadmission screening requirements went

into effect. This patient was not allowed to return to the facility. There is no other placement for this woman locally, and she will likely be moved to a location where MR/DD services are available. She will be forced to leave her community, family and the facility that was her home for 14 years--all because Congress passed a law--a law that might work in some places where alternatives are more readily available--but not in a community of 900 in northeastern Montana.

Montana's long term care facilities are attempting to cope with all of these new requirements. Of great frustration to us as we do this are the mixed signals coming from Washington. As providers, we have pushed our state agencies for information and instructions on implementation of OBRA, only to be told that they were waiting for the Health Care Financing Administration in Washington to provide regulations. HCFA has missed every implementation deadline contained in the federal law and so have our state agencies. Congress has condoned this by including a provision in the law, that requires facilities and states to comply with the law, even if the federal government doesn't. It's an untenable situation, with providers caught in the middle.

In addition to all of this, funds to pay for the care we provide are becoming more and more limited. Long term care facilities are being asked to care for sicker patients; to increase staff and services despite a shortage of licensed nurses; and to do more and more paperwork to document the care

being given;...and to do it all with inadequate funds and without flexibility to accomplish tasks in the most cost effective ways.

Our ability to meet the needs of our patients will depend on a combination of things, the most important of which are: (1) adequate funding; and (2) a regulatory arena that allows maximum flexibility to states and facilities to find solutions and reach goals in ways that are both economic and fruitful in terms of leading to high quality services to our patients.

Providing long term care services in Montana is more difficult than in states where there are larger concentrations of people and smaller geographic areas to cover. But we're accustomed to the challenge of living where we live. We've learned to work together and to find creative solutions to problems, and to attain good results with fewer resources than others have available. That is why it is so important that the solutions found in Washington for problems relating to the financing and quality of long term health care take into account the unique characteristics of states like ours. We must be allowed to apply Montana solutions to our problems.

I appreciate the opportunity to present our views today, and I would be happy to answer any questions you may have or provide additional information you may request.

EXHIBIT 1

COST PROJECTIONS:

MONTANA IMPLEMENTATION OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (P.L. 100-203)

EXECUTIVE SUMMARY

A detailed analysis of the costs associated with implementation of the Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987, passed by the U.S. Congress on December 22, 1987.

November 1, 1988

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THE COST OF OBRA: MONTANA

EXECUTIVE SUMMARY

In December, 1987, Congress passed the Omnibus Budget Reconciliation Act of 1987 (OBRA), which included "nursing home reform" provisions which mandate major changes in services, staffing, training and other requirements for nursing homes, and mandates that state Medicaid programs recognize the costs associated with compliance with these new requirements when setting Medicaid nursing home rates.

The Montana Health Care Association (MHCA), which represents over 80 percent of all non-state skilled and intermediate care facilities (nursing homes) in Montana, contracted with the accounting firm of BDO/Seidman, of Milwaukee, Wisconsin, and the law firm of Pierson, Ball & Dowd, of Washington, D.C., to conduct a survey and otherwise assist in the accurate determination of what the cost of OBRA will be in Montana.

The survey was conducted in May, 1988, and 83 of Montana's 93 licensed non-state nursing homes responded to it--a nearly 90 percent response rate.

OBRA envisions an enormous amount of state and federal rulemaking, and in most instances the regulations have not yet been finally developed. However, because the 1989 legislature will soon convene to consider state budgets for fiscal years 1990 and 1991, it was necessary to project OBRA costs using the best information available at this time.

Our projections of what the requirements will cost facilities, and the Medicaid program, are based on the "incremental" costs associated with compliance using the survey to determine the baseline data of what facilities

were doing pre-OBRA, and what it is costing facilities currently to do those things they are already doing.

We have reviewed each significant change mandated by OBRA and provided projections of the costs associated with each.

Our report includes a full discussion of the actual cost projections related to each requirement; what the law or proposed regulations require; what assumptions have been made in projecting costs; effective dates; federal matching percentages; and facility costs not included in our projections.

Our projections only cover service expenditures (Medicaid portion) of non-state nursing facilities to comply with OBRA, and do not include state facility costs or state administrative expenditures to comply with the law. There will be enhanced federal matching funds available for state administrative costs, but federal financial participation will remain about the same for facility costs. Our calculations assume a federal matching rate of 70.62 percent throughout, based on Montana's FY 1990 matching rate.

PROJECTED COSTS: NURSE AIDE TRAINING

The following are the most significant requirements related to nurse aide training:

1. Training and competency evaluation for new and existing nurse aides, including a minimum of 75 hours of training for new aides.
2. Ongoing training of 2 hours per month for all nurse aides.
3. "Train the trainer" training for those in charge of facilities' training programs.

We assumed that our nearly 3,000 current aides will receive 35 hours of "retraining" to enable them to pass the competency evaluations. This amounts to 105,000 hours of training for current employees.

Likewise, our nearly 2,500 new aides each year will have to receive 75 hours of training--amounting to 187,500 hours of training for new aides alone.

In addition, costs will include "train the trainer" courses for our nurses in charge of the programs, time spent in the classroom teaching, training equipment and materials, and overtime pay for some trainers, trainees, and trained staff occasioned by the training requirements and need for staff for resident care. Too, we will be expecting far more training, testing, and responsibility than other jobs which pay a similar wage, and to compete in the market place, wages for nurse aides will be raised.

The estimated costs of nurse aide training are:

	FY 90	FY 91
Train the Trainer	$ 186,081	$ -0-
Train Existing Aides	1,606,203	-0-
Retrain Existing Aides Who Fail Test	361,232	-0-
Train New Aides	1,376,519	1,445,346
Retrain New Aides Who Fail Test	123,423	141,375
Ongoing Education	790,427	829,949
Supplies and Training Materials	127,848	-0-

Increase nurse aide wages from "untrained" to "trained" level	1,999,006	4,197,912
TOTAL PROJECTED COSTS-- NURSE AIDE TRAINING	$6,570,739	$6,614,532

PROJECTED COSTS: NURSE STAFFING

OBRA eliminates nurse staffing distinctions between skilled and intermediate care facilities effective October 1, 1990, requiring all facilities to maintain RN staffing at least 8 consecutive hours a day, 7 days a week, and licensed staffing (LPNs or RNs) 24 hours a day, after that date.

Our intermediate-care-only facilities are expected to incur the following costs:

	FY 90	FY 91
RNs 8 hours a day, 7 days a week	$ -0-	$ 74,032
24-hour licensed nursing	-0-	130,249
TOTAL PROJECTED COST - NURSE STAFFING	$ -0-	$204,281

PROJECTED COSTS: QUALITY ASSURANCE

OBRA requires all nursing homes to maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff. The committee must meet at least quarterly, identify problems, and develop and implement plans of correction for identified deficiencies.

Nearly 60 percent of Montana's nursing homes do not currently have such committees, and of those that do, many fail to meet the specific criteria specified in the new law.

The projected costs associated with Quality Assurance under OBRA are:

	FY 90	FY 91
TOTAL PROJECTED COSTS-- QUALITY ASSURANCE AND ASSESSMENT COMMITTEE	$ -0-	$350,157

PROJECTED COSTS: ASSESSMENTS, REVIEWS AND PLANS OF CARE

OBRA requires that written plans of care describing a resident's medical, nursing and psychosocial needs and how to meet them be prepared by the attending physician, the responsible RN, and the resident and his family. These plans must be prepared upon admission and reviewed and revised at least once every 12 months and upon significant change in the resident's condition. They must be signed and certified as to accuracy by the professionals involved in their preparation.

While all facilities perform some level of patient assessment, reviews and care planning, the specific process prescribed by OBRA exceeds what many of our facilities are doing currently, particularly with respect to physician involvement on the care planning team, use of a standardized assessment tool, and certification by each discipline involved in the process.

The projected costs of complying with OBRA's requirements for assessments, reviews and plans of care are:

	FY 90	FY 90
TOTAL PROJECTED COSTS - ASSESSMENTS, REVIEWS, AND PLANS OF CARE	$ -0-	$845,759

PROJECTED COSTS: SOCIAL SERVICES AND SNF/ICF DISTINCTION

Effective October 1, 1990, nursing facilities with more than 120 beds must have at least one full-time bachelor's degree social worker to furnish social services to patients. In addition, OBRA eliminates the distinction between SNF and ICF nursing facilities, making all SNF standards applicable to ICFs, including standards for a qualified dietitian, pharmacy consultant, medical records practitioner, medical director, and infection control committee.

The projected costs of meeting these requirements are:

	FY 90	FY 91
Full time bachelor's degree social workers for facilities over 120 beds and social work consultants for ICFs not meeting current SNF standards	$ -0-	$230,622
Qualified Dietitian for ICFs not meeting current SNF standards	-0-	14,859
Pharmacy Consultant for ICFs not meeting SNF standards	-0-	36,254
Medical Records Consultant for ICFs not meeting SNF standards	-0-	21,663
TOTAL PROJECTED COSTS - SOCIAL SERVICES AND SNF/ICF DISTINCTION	$ -0-	$303,398

PROJECTED COSTS: PHYSICIAN INVOLVEMENT

OBRA eliminates the distinction between SNF and ICF nursing facilities, thereby requiring ICFs to employ a Medical Director.

We project this will cost:

	FY 90	FY 91
PROJECTED COSTS - MEDICAL DIRECTOR	$ -0-	$27,263

PROJECTED COSTS: MISCELLANEOUS

Miscellaneous OBRA provisions and pending regulations require facilities to handle and account for personal funds of residents, including deposit in interest bearing accounts, and purchase of a surety bond; to provide "full visual privacy for residents" (which requires circular curtains around all beds); and to meet infection control standards including those relating to isolation areas and the use of rubber gloves.

Based on the survey, we project the costs associated with these requirements to be:

	FY 90	FY 91
Patient Trust Funds	$ -0-	$ 20,514
Privacy Curtains	-0-	403,480
Infection Control	-0-	Unknown
TOTAL PROJECTED COSTS--MISCELLANEOUS	$ -0-	$423,994

CONCLUSION

The Omnibus Budget Reconciliation Act of 1987 imposes on nursing homes significant changes in staffing, services, documentation, and training which will raise the costs of care. The provisions go into effect at different times, some as early as January of 1989 and some as late as October 1, 1990.

Much of what is contained in OBRA remains to be sorted out. For example, new Conditions of Participation implementing new "quality of life" and "resident rights" provisions are yet to be developed. We have not projected costs associated with what is expected to be these generally stronger conditions of participation.

Our report sets out projections for costs associated with those provisions of OBRA which are specific enough and clear enough to put us on notice of what will be required or to at least allow us to make reasonable assumptions about what will be required.

This report does not include all of the costs that will ultimately be associated with the Nursing Home Reform provisions of OBRA. However, the costs we can reasonably project at this time are in fact incorporated in this document.

A summary of these projections follows, including implementation dates, and a break out of state and federal funding. (Attachment 1 to Executive Summary.)

Executive Summary - Attachment 1

SUMMARY OF COST PROJECTIONS

Category/ Cost Effective Date	FY 1990	State Funds 29.38%	FY 1991	State Funds 29.38%
Nurse Aide Training (07/01/89)	$6,570,739	$1,930,483	$6,614,582	$1,943,365
Nurse Staffing (10/01/90)	-----	-----	204,281	60,018
Quality Assurance (10/01/90)	-----	-----	350,157	102,876
Assessments, Reviews, and Plans of Care (10/01/90)	-----	-----	845,759	248,484
Social Services/SNF/ICF Distinction (10/01/90)	-----	-----	303,398	89,139
Physician Involvement (10/01/90)	-----	-----	27,263	8,010
Miscellaneous	-----	-----	423,994	124,569
TOTAL COSTS - ALL CATEGORIES	$6,570,739	$1,930,483	$8,769,434	$2,576,461

STATE AND FEDERAL FUNDS REQUIRED BY FISCAL YEAR

State Fiscal Year	Total Cost	State Funds	Federal Funds
1990	$ 6,570,739	$1,930,483	$ 4,640,256
1991	8,769,434	2,576,461	6,192,973
TOTAL FOR BIENNIUM	$15,340,173	$4,506,944	$10,833,229

EXHIBIT 2

Policy Perspective

CARE AT NO DIRECT COST TO RECIPIENTS? IT CAN'T BE DONE

Robert Froisness

While basic demographics clearly show many positive indicators relative to the future of the long term care industry, we have yet to develop an appropriate funding source through which our industry can provide both the quality and the quantity of care which will be required into the 21st century. Consider the meaning behind each of these recent occurrences:

Item: The Medicare Catastrophic Coverage Act of 1988 substantially increases both Part A and Part B benefits available under Medicare. Nonetheless, some consumer groups vigorously protest the increased Part B monthly premium and the Part A "supplemental premium," even going so far as to call for repeal of the act, while still campaigning for "more meaningful" long term care legislation.

Item: Though the number of private long term care insurance policies in force have increased dramatically during the past four years, insurance companies indicate that general acceptance of this product will not be achieved in the near future. They also state that the uncertain costs associated with eventual benefits are forcing them to set premiums somewhat higher than originally anticipated.

Item: The Omnibus Budget Reconciliation Act of 1987 places numerous new and increased requirements upon our industry, but neither the federal government nor the individual states seem particularly eager to pay the bill. Nonetheless, the new requirements will go into effect and be enforced by surveyors who have no obligation to consider a facility's financial viability, but seek only to determine whether or not each additional requirement is met in full.

Item: A mid-western state is forced to admit in court that its Medicaid long term care reimbursement plan pays the full costs of less than 40 percent of its providers. As a partial defense, the state points to its huge budget deficit. A general tax increase is considered to be out of the question, although expansions in program eligibility seem to occur every year.

Each of these examples serves to illustrate the basic point that while needs and recipient benefits are rapidly increasing, no one is willing to step forward and declare a readiness to pay the inevitable costs — not the elderly or their families, not the younger working population, and certainly not the government.

Medicaid's policy of mandatory impoverishment has proven itself wholly ineffective in dealing with the problem, instead fostering a mini-industry specializing in "protecting" assets while helping to obtain faster Medicaid eligibility. Medicare provides for only a small fraction of long term care needs, often helping those who need the help the least.

Voluntary private long term care insurance may be of some value in the future, but few now expect it to play a significant role anytime soon because the public's perceived need for this type of protection is virtually nonexistent, particularly among younger individuals. How many of you have personally purchased a long term care policy? Short of government-mandated coverage, would you personally buy such a policy for yourself — right now — even at $18 to $25 per month? Experience now suggests that the answer is a resounding "No."

'No More Free Lunches'

So what then is the solution? What does it mean for future funding when the elderly of today (who are the wealthiest group of elderly in history) complain so loudly about a relatively modest increase in Medicare premiums, even when that increase is coupled with significantly expanded benefits? How can the demand for ever-increasing benefits be met by fewer and fewer working individuals per elderly person? Simple budgetary economics cannot be ignored forever. Sooner or later, either someone pays the bill or the "free lunch counter" becomes bankrupt and serves no more free lunches.

What will be required is a program which makes maximum use of available resources while providing assistance only where it is truly required. Despite the howls of protest from virtually every segment of modern society, I would suggest that such a program should include elimination of the current Medicare long term care benefit, and the creation of a new income-related Medicare-based program covering all levels of long term care.

This type of program would not use Medicaid's "all or nothing" philosophy of eligibility, but rather a sliding fee schedule tied to the gross income and assets of the beneficiary and his or her extended family. Individuals and families most in need would be helped the most, while those with greater resources would be expected to pay a progressively increasing share of the cost of care.

Such a scheme would greatly reduce the incentive for middle class elderly to "voluntarily" impoverish themselves (as occurs now under Medicaid) and would also eliminate payments made on behalf of people who simply do not need the assistance (as often occurs now under Medicare).

Intergenerational Sharing of Costs

In addition, this type of program would emphasize not only family responsibility but also promote an inter-

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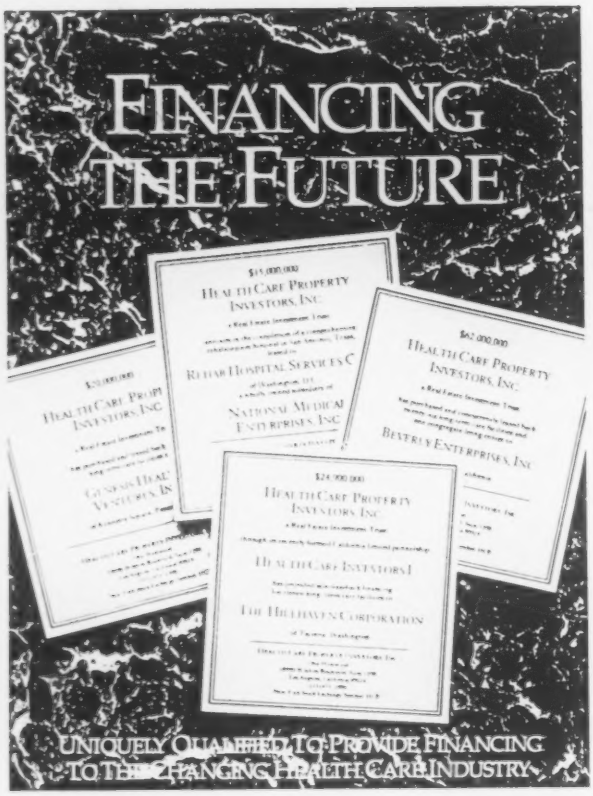

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generational sharing of the costs of long term care. Increased financial participation on the part of program beneficiaries (and their families) could well serve to minimize the increased Social Security taxes which will inevitably have to be levied against the relatively diminished working population, possibly making those increases somewhat more palatable to future generations.

This type of proposal could easily be tied to an equitable reimbursement methodology in one of two ways: either the beneficiary's fee-schedule-determined share of costs could be applied toward a government-driven payment mechanism, or, in the reverse, the government's fee-schedule-determined share could be given directly to the beneficiary in the form of a voucher to be used to assist in the independent purchase of care. Of the two possibilities, the latter would have the added benefit of drastically reducing bureaucratic costs, interference, and inefficiencies.

The dream of universal health care available at no direct cost to the recipient can never be realized in this country for a wide variety of social, demographic, political, and financial reasons. The illusion of Social Security and Medicare as annuity-based retirement-funding mechanisms has long since been discredited by many consumers and virtually all economists — these programs may have been sold to the public on that premise, but they certainly were not designed to actually operate that way. In fact, an individual retiring in 1989 will have made payroll tax contributions (including his or her employer's share and all accumulated interest) totaling less than 50 percent of the Medicare benefits he or she can expect to receive during his or her lifetime.

Time to Face Reality

Therefore, I would suggest that it is time finally to face reality and design a system that ensures the availability of care for those who need it, but which also utilizes a reasonable portion of the resources created, amassed, and available to elderly individuals and their families. This basic concept will not simply be one potential approach in the 21st century — it could well prove to be the only available course of action.

A true three-way partnership which includes the elderly, their family members, and the rest of the working population is likely to be the single viable method for securing appropriate long term care funding for the future. A system missing any one of these three essential supports simply will not stand. ■

EXHIBIT 3

Issue

Enact Long Term Care Financing Legislation

Background

Long term care is the most likely catastrophic illness risk facing individuals and families. From the elderly's perspective, their primary out-of-pocket health expense is for long term care, which is more than the combined personal expense of hospital and physician care. In fact, approximately 82 percent of out-of-pocket costs for elderly persons who incur catastrophic medical expenses is spent on nursing home care.

Every demographic trend shows that the need for long term care services is going to increase and will continue to strain governmental budgets. Clearly, there is a lack of comprehension on the part of many individuals about the financial risk they run in the event that they would need long term care. Unfortunately, most elderly erroneously believe that Medicare pays for nursing home coverage; they do not recognize the very limited nature of the skilled nursing benefit. By default, Medicaid, which forces individuals to "spend down" and divest themselves of their assets, has become the major governmental payor for both nursing home and catastrophic expenses. Changes must be made to provide protection for those needing long term care, as well as to encourage the elderly to purchase private insurance to cover the costs of meeting their long term care needs.

Status

Last year, Congress passed the Medicare Catastrophic Coverage Act (P.L. 100-360), which was designed to protect the elderly from catastrophic acute health care expenses. The so-called catastrophic legislation provides limited benefits at considerable expense to Medicare beneficiaries, but leaves the elderly exposed to their greatest health care risk – paying for nursing home care. Recognizing the long term care coverage gaps left by the catastrophic legislation, several members of Congress have developed comprehensive long term care financing plans.

Senator George Mitchell (D-ME) has promoted the "Long Term Care Assistance Act," which would expand Medicare to cover nursing home care after a two-year exclusionary period during which beneficiaries would be responsible for their own care through personal resources or insurance. The bill includes tax incentives for employees and employers to purchase long term care insurance that could help cover the deductible period and patient copayments.

Congressmen Henry Waxman (D-CA) and Pete Stark (D-CA) are promoting similar proposals to expand Medicare to cover nursing home, home health and adult day care. The exclusionary periods for nursing home coverage in their plans, however, would be 60 days and 90 days, respectively. The legislation would be financed primarily through increased payroll FICA taxes and higher estate taxes.

Senator Edward Kennedy (D-MA) is promoting a "Life Care" plan which would provide six months of nursing home care and unlimited home health care to Medicare beneficiaries. An optional benefit could be purchased by individuals age 45 and over to cover nursing home stays in excess of six months.

AHCA's Position

Of the proposed financing options, AHCA endorses the Mitchell "stop-loss" concept for long term care financing. We feel it is a responsible approach which balances individual and family responsibility with appropriate governmental assistance. Rather than first-dollar coverage, the "stop-loss" approach would make an individual responsible for long term care costs for a set deductible period, which would create strong incentives to purchase private insurance to cover that deductible period. Insurance companies would have a defined period of risk -- leading to lower-priced insurance premiums which would be affordable to a much greater proportion of the elderly. Clearly, the success of this approach depends on the response of the private long term care industry in the development of improved insurance policies. According to a recent study by the Brookings Institution, nearly 70 percent of the elderly would be able to afford a limited long term care policy.

AHCA feels that the "stop-loss" approach is more viable than the Kennedy bill that provides first-dollar coverage of nursing home care with no deductible or

copayment. This concept would result in nearly complete federalization of long term health care, which would drain the federal budget as well as eliminate the legitimate role that the private insurance sector should play in the financing solution. First-dollar coverage would also likely create a massive "wood-work" effect that would generate increased utilization -- a particular concern with long term care since a large percentage of long term care is provided by families and informal caregivers.

AHCA has similar concerns about the Waxman and Stark proposals, which have very short exclusionary periods for nursing home care. The proposed 60-day or 90-day deductible period would not provide incentives for individuals to self-insure against their long term health care risk, and would leave virtually no role for the private insurance market. AHCA is strongly committed to the concept of a public/private partnership as the solution to the long term care financing dilemma.

AHCA's Action Plan

AHCA will encourage enactment of a long term care financing plan as the next step that Congress should take to close the last major hole in the elderly's health safety net. AHCA will work to promote Senator Mitchell's "stop-loss" financing concept as the most politically feasible and financially responsible approach to long term care. From the perspective of nursing home providers, Congress must consider several important issues:

- *A sound, designated funding source must be developed that avoids the need for future financing from general federal revenues;*
- *The Medicare reimbursement system must be adequate to ensure that providers can provide quality care that meets the varied needs of patients;*
- *Clarification must be made to ensure that individuals may purchase additional services in a nursing home over and above what may be covered under the Medicare reimbursement rate;*
- *Because of cost issues, a financing plan must maximize the use of private resources for individuals who can afford to pay for their own long term expenses;*
- *Federal tax incentives must be provided for the purchase of private long term care insurance;*
- *Congress should enhance consumer protection and confidence in the long term care insurance market by establishing a program of voluntary certification for insurance policies.*

5/89

Issue

Remove Medicaid Reimbursement Limit

Background

The Medicare upper payment limit (UPL) requires that state Medicaid programs assure HCFA that their respective reimbursement systems result in expenditures that are no higher than what would have been incurred for similar services using the Medicare principles of reimbursement.

There is no statutory requirement for the UPL as applied to state Medicaid reimbursement programs, only committee report language referencing congressional intent. Senate Finance Committee report language relative to Section 962 of the Omnibus Reconciliation Act of 1980 (P.L. 96-499) stated that payment systems not exceed what would have been paid under Medicare cost principles and specified that "the Secretary would only be expected to compare the average rates paid to SNFs participating in Medicare with the average rates paid to SNFs participating in Medicaid in applying this limitation."

Status

On July 28, 1987, HCFA issued final regulations on Medicaid payments for hospital and nursing home services, including a revised -- but more restrictive -- Medicare upper limit provision. According to these regulations, application of the Medicare UPL to Medicaid payments is required for each separate category of facility services (e.g., hospital, skilled nursing facility (SNF), intermediate care facility (ICF), and intermediate care facilities for the mentally retarded (ICFs/MR)) and must be separately applied to state-owned facilities. In addition, HCFA must, by regulation, deny federal financial participation (FFP) to states for any Medicaid payments to hospitals or nursing homes that exceed the UPL.

AHCA's Position

The Medicare UPL is not relevant to state Medicaid nursing home payments. Continued federal application of the Medicare upper limit test on state Medicaid programs will

- *Restrict state administrative flexibility;*
- *Require Medicaid reimbursement linkage to inefficient and inflationary Medicare principles;*
- *Restrict states from developing cost-effective special care programs and prospective case-mix payment systems; and*
- *Lead to greater overall public health care spending.*

AHCA's Action Plan

AHCA will seek legislation to prevent HCFA from applying the UPL as part of its regulations implementing Section 1902 of the Social Security Act on state Medicaid programs.

5/89

Issue

Ensure Quality Standards for Community Services

Background

In the Omnibus Reconciliation Act of 1981, Congress established a program that allows states, on a limited basis, to provide home- and community-based services under Medicaid. This program allows states to apply to the Health Care Financing Administration for "Section 2176 waivers" to fund care in alternative settings for low-income elderly at risk of institutionalization. The waiver program makes available a wide range of home health and community services that Medicaid previously had not covered.

Since the program's inception, 37 states have applied for and been granted waivers. However, many states have criticized the approval process required every three years as unnecessarily burdensome and costly. Responding to these concerns, Congressman Ron Wyden (D-OR) and Senator Jay Rockefeller (D-WV) have introduced legislation (H.R. 1453 and S. 785) to give states the option under their Medicaid programs to offer home- and community-based services without applying for the waiver.

Both measures would allow state Medicaid programs to offer homemaker/home health aide services, chore services, adult day care, foster care, board and care, and other noninstitutional services. These services would be provided to low-income, functionally disabled elderly according to an individualized care plan administered by a case manager.

The legislation also requires the establishment of minimum federal quality standards, as well as monitoring and enforcement procedures, for community-based care settings. The quality provisions stem from a recent General Accounting Office study which found serious problems, including physical abuse, unsanitary conditions, and lack of medical attention, in many board and care facilities.

Status

H.R. 1453, which was introduced March 15, is currently pending before the House Energy and Commerce Committee. Chairman of the Energy and Commerce health subcommittee Henry Waxman (D-CA) has targeted the legislation as one of the primary initiatives he will pursue in the budget reconciliation process this year.

S. 785 is pending before the Senate Finance Committee.

AHCA's Position

While AHCA has no formal position on the bills, we do have several serious concerns about the proposed legislation. Under the bills, Medicaid would pay for the services provided in board and care facilities, as well as other community-based settings. This is a major new initiative that may create significant problems in several states by blurring the distinction between providers of health care and providers of custodial services.

In addition, we believe that federal standards are necessary in community-based settings to ensure uniform, quality services and resident protections. We feel that legislators must ensure that all providers meet high standards of quality: adequate numbers of trained staff, safe and sanitary physical plants, residents' rights, and adequate attention to resident care needs. Moreover, we feel that inspections by trained surveyors and enforcement mechanisms would provide needed improvement in monitoring the quality of services.

Finally, AHCA feels that decisions on placement of the frail elderly must be based on the needs of the individual. Program options, such as the Section 2176 waiver, should not be viewed as a cost containment mechanism.

AHCA's Action Plan

As Congress reviews proposals to make home-and community-based services a state option under Medicaid, AHCA will urge legislators to consider three key issues.

First, federal standards are essential in community-based settings to ensure basic patient protections.

Second, the definition of a "functionally disabled

elderly individual" should ensure that states cannot inappropriately place nursing care patients in personal care facilities. For example, a person who is bedfast should be placed in a nursing facility where staff is trained to lift and move residents and provide preventive skin care.

In addition, the definition of "community care" should not include nursing care. In community-based settings, "intermittent or temporary nursing care" should be defined as preventive or wellness care, as opposed to general and restorative nursing that is provided in a nursing home during periods of recovery from an illness, accident or other health condition.

AHCA will continue studying this issue and its implications.

5/89

Issue

Ensure Adequate SSI Benefits

Background

Residential care, also referred to as board and care, is a valuable service in the long term care continuum. Designed to provide assistance with the activities of daily living, residential care is appropriate for the frail elderly who need 24-hour supervision but not the professional services offered in a nursing home.

Unlike other segments of the long term care continuum, residential care is not covered by Medicare or Medicaid. Payment is through residents' private funds or Supplemental Security Income (SSI) benefits.

In recent months, congressional hearings have been held to discuss several issues related to the residential care setting. These include major variations in the size of facilities, the number of staff, and the quality of services.

Status

Several legislative proposals, which would affect residential care, have been introduced in Congress. First, a package of bills to revise the SSI program and increase benefits has been introduced and referred to the House Ways and Means Committee.

In addition, Congressman Claude Pepper (D-FL) has introduced the National Board and Care Act (H.R. 2219), authorizing a 20 percent increase in SSI payments for residents of facilities which meet national quality standards. Enforcement provisions also are included in the bill.

AHCA's Position

Residential care should be encouraged as an appropriate setting for the frail elderly in need of daily personal assistance. The current federal benefit of $368 per month is inadequate to allow individuals to purchase appropriate residential care, which averages $30 per day. AHCA believes the federal benefit should be increased for residents of licensed residential care facilities. Further, the state supplement must be sufficient to purchase care in facilities that meet state standards.

AHCA also supports the initiation of a major study of board and care issues related to licensing, quality, and funding.

AHCA's Action Plan

AHCA will encourage Congress to increase the federal SSI benefit to an amount sufficient to at least a safety net level that will enable purchase of quality residential care. AHCA also will urge Congress to incorporate provisions of the SSI and Pepper bills into this year's reconciliation package.

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Issue

Allow Fair Competition Among Providers

Background

An erosion of the competitive position of nursing homes relative to other long term care providers has occurred for a variety of reasons in recent years. The abandonment of federal health planning has removed the framework for orderly competition and encouraged states to place restrictions on nursing home bed supply as a means of controlling costs. The result, however, has been nursing home bed shortages in many areas of the country.

To fill the gap, many hospitals have established a distinct part of the facility exclusively for providing skilled nursing facility (SNF) care. While required to meet the same standards and provide the same services as a Medicare-certified nursing home, hospital distinct parts are reimbursed at a higher rate. Specifically, routine cost limits or "Section 223" limits, which place a cap on inpatient routine service costs, are higher for hospital-based distinct parts than for free-standing nursing homes.

Status

Current laws give hospitals a competitive advantage over nursing homes, by allowing a routine cost limit differential between free-standing nursing homes and hospital distinct parts under the presumption that hospitals care for sicker patients than do SNFs. And while several states have implemented case-mix reimbursement systems under Medicaid as a means of linking reimbursement levels to the type of patient care provided, such systems are only now being proposed to replace the current Medicare reimbursement system.

AHCA's Position

AHCA believes that in the short-run, Congress should ensure that nursing homes and hospitals receive the same reimbursement for the same services. By maintaining separate limits for routine costs, Congress has given hospital-based providers an unfair competitive advantage over free-standing nursing homes. This is particularly troublesome since the latest data indicate that SNF patients in hospitals are, on average, no sicker than those in freestanding SNFs.

In the long-run, Congress should consider implementing a case-mix reimbursement system, which would tie reimbursement levels to patient acuity rather than type of provider.

AHCA's Action Plan

AHCA will seek the following changes:

- *In the short run, to replace the current dual "Section 223" routine cost limit system with a single limit for routine service costs under Medicare and*
- *In the long run, to introduce a new prospective payment system for all Medicare SNFs that includes efficiency incentives for non-nursing routine costs, case-mix reimbursement for nursing service costs, charge-based reimbursement for ancillaries, and fair rental reimbursement for property costs.*

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Chairman BAUCUS. Thank you, Rose. You're next, go ahead.

STATEMENT OF KAY JENNINGS, DIRECTOR, CERTIFIED HOME HEALTH AND MEDICAID WAIVER PROGRAMS, SYDNEY, MT

Ms. JENNINGS. My name is Kay Jennings and I'm from Sidney, MT, a town of 5,700 people in eastern Montana. And, in fact, the air service there over to here is not good, but it's there.

Chairman BAUCUS. That's an entirely different matter.

Ms. JENNINGS. I'm the director of a Medicare certified home health agency and I also direct a Medicaid Waiver Program. I'd like to first give you an explanation of both of these long-term care components and then clarify them with an actual case study.

A home health agency is an agency primarily engaged in providing skilled nursing and other therapy services, such as physical therapy and speech, on an intermittent basis to patients in their home under a plan of treatment prescribed by the attending physician. An easy example would be a homebound patient in need of a weekly injection, which the R.N. would go out and give under the physician's orders.

The Medicaid Waiver Program, also known by the name of Home and Community Services, is designed to care for the poor, frail elderly, and disabled who are at risk of institutionalization. The main thrust of this program is to provide case management to coordinate the many services in the community, to set up a support system, and to see that these patients' multiple needs are met. An example of this would be a 75-year-old widow on a low, fixed income who has early Alzheimer's and is unable to prepare meals or take her medications because of forgetfulness and needs assistance in and out of the tub. Without the Medicaid Waiver Program, this woman would most likely be institutionalized. The cost of the program must remain below what it would cost if the person were in a nursing home. Many of these patients are cared for in their home at a much lower cost than if they were placed in a nursing home.

I'd like to share a case study of a couple we recently cared for in Sidney, MT. The case management team received a referral from both the hospital and the physician, who asked them to see this couple and figure out a discharge plan. The physician felt that this couple must either be placed in a nursing home or into the Waiver Program. Mr. C was an 81-year-old male with early stage Alzheimer's and diabetes controlled with diet and pills. Mrs. C was a 67-year-old female with cancer of the facial sinuses. She had one eye removed and her vision was poor in the other eye. Due to her weakness, she was no longer able to monitor her husband's wandering and was unable to attend to meals or housework.

The case management team went in and first determined that this couple needed to apply for Medicaid in order to be eligible for Waiver services. They immediately put a personal care attendant, PCA, into the home 8 hours per day, 7 days a week to help attend to Mr. C's wandering, to prepare meals, to assist with bathing, to shop, to remind them of their medications, and to do light housekeeping. The personal care attendant also helped to transport Mrs. C to the doctor for weekly chemotherapy. A medical alert system

was also placed in their home. When Mrs. C was hospitalized for an infection, we were able to provide respite care to Mr. C in his own home. The case management team also arranged for a Medicare certified home health agency to provide for the every-other-day wound irrigations by an R.N. for Mrs. C. This couple was maintained at home for 11 months, at which time Mrs. C went totally blind. They were placed in a nursing home and remained there until Mrs. C's death 2 months later. Mrs. C often voiced her gratitude for being able to stay in her own home with her husband until the end. The total cost to the system for the care provided through Medicaid Waiver for 11 months was $11,194, versus $29,538, figured conservatively, if they were both institutionalized for the same amount of time.

Home Health and the Waiver are wonderful programs that really improve the quality of life and are cost-effective, but they do have some glaring problems. The Medicare Home Health benefit does not allow for chronic personal care in the home. A Medicare beneficiary, who is not Medicaid eligible, will end up institutionalized if their needs for assistance with ADL's [activities of daily living] and other things are not met by family or friends.

The increased number of licensed home health agencies has also led to another problem, competing for the few nurses that reside in rural areas.

The Medicaid Waiver Program in eastern Montana has a waiting list and not nearly enough slots for the people who qualify for the service. It also does not address the needs of disabled children trying to be cared for in their own homes.

Another problem is that the middle income, who are too wealthy to be eligible for Medicaid, yet unable to pay for care themselves, this group just happens to fall through the cracks.

I feel the four biggest problems faced in providing inhome care in eastern Montana are access to the inhome health care system, affordability of services for the middle-income class, inadequate manpower to staff the programs, and fragmentation of care. And some of the possible solutions would be to expand the Medicare Home Health benefit to help delay institutionalization, increasing the number of slots and sites of the Medicaid Waiver Program, providing rural incentive scholarships on the State and Federal level for R.N.'s, have a centralized intake point for people needing inhome care, and trying to discourage the duplication of services in rural areas. Thank you.

Chairman BAUCUS. Thank you very much, Kay. OK, David, you're next.

STATEMENT OF DAVID B. WHEELER, REPRESENTING MONTANA NURSES ASSOCIATION

Mr. WHEELER. Thank you, Senator Baucus. I'm David Wheeler and I live here in Missoula. I graduated from the University of Montana this spring with high honors in zoology and pre-med. I have been elected to a Rhodes Scholarship and will spend the next 2 years at the University of Oxford studying human physiology. Following that I will be attending Stanford Medical School, where I hope to obtain joint M.D. and Ph.D. degrees. I am planning to

study the genetic and physiological bases of neurological disorders and I am most interested in degenerative diseases, such as Alzheimer's and Parkinson's. As I hope to devote much of my life to laboratory and clinical research of these debilitative afflictions, I obviously have a vested interest in the establishment of comprehensive programs for long-term health care in this country.

Although I'm neither a nurse nor a member of the organization, I'm here at the request of the Montana Nurses Association in order to discuss my experiences as a member of a nursing facility. From July 1988 through February 1989, I worked part time as a nursing assistant in a local nursing home. In this kind of a facility, nursing assistants provide at least 80 percent of the direct patient care. From this position, therefore, I was able to observe first hand the negative effects of inadequate funding for long-term health care. Most of the problems I saw could be directly attributed to poor working conditions and low wages.

Because nursing homes cannot afford to pay much more than minimum wage, much less provide any kind of meaningful benefit package, they have a great deal of difficulty attracting good workers. They suffer from a very high turnover rate, which not only increases operating costs for the facility, but also reduces the morale of those who choose to stay, and ultimately impacts on the quality of patient care. The major problem where I was employed was that we worked a large proportion of our shifts shorthanded. This was either because an aide had abandoned his or her position or because he or she didn't have adequate motivation to come to work. Because we were so often shorthanded, new workers seldom received adequate training before assuming full responsibilities. When I started working, I was to have received 3 days of orientation. But after only one shift, I was placed on a hall without a trainer. This is a common occurrence; as most of my fellow employees told me, they also had this same experience, and many workers never came back after their orientation period.

There seemed to be two distinct categories of assistants at this facility. First, there were the people hired off the streets with no particular commitment to health care, and because of the embarrassingly low wages and extreme difficulty of the work, they have very little incentive to stay on the job. The second category were individuals with a strong commitment to the caring profession, who took a great deal of pride in their work. The facility relies heavily on these individuals and regularly calls them to fill in for those who call in sick every day.

One of my coworkers has been on the job for nearly 15 years. She loves her work, but she's paid less than $5 per hour. Needless to say, she is tired, frustrated, and questioning whether or not she can continue as a nursing assistant. None of these people are in this for the money. They do their job for the personal satisfaction they gain in making a positive contribution to their patients' lives. The constant need to cover for their absent coworkers and lack of recognition emotionally and physically is draining and is more than merely taking care of dying human beings. Ultimately, these problems strongly detract from the facility's primary mission. The quality of patient care declines dramatically as absenteeism increases. When we were shorthanded, we weren't able to shave their

faces, and, perhaps most importantly, we weren't able to spend time talking to them and providing the emotional care that is so necessary the rest of their lives. After several days of doing the physical work of two aides, even the most dedicated caregiver can become careless and inadvertently cause a medical problem. The tired aide might drop a patient while performing a transfer or he or she might mishandle a catheter, resulting in a urinary tract infection. Furthermore, the overworked aide quickly loses the ability to be friendly with the patients, and this can be as damaging as any physical trauma. In short, I've seen the inadequate wages for nursing assistants has direct negative effects on patient care.

Almost everyone agrees that we need to allocate more resources to long-term care. As our population grows older, I believe that the number of voices in favor of this position will increase, and our society seems to have adopted the view that adequate medical care is a fundamental human right, but we, as a Nation, cannot afford to devote much more of our resources to this cause. As there does not seem to be any way to halt this spiralling increase in the cost of medical care, it is time for us to begin looking at ways of reallocating the resources we already devote to the cause. Unless and until we Americans come to the resounding conclusion that preparation for war is not a legitimate pursuit, our resources will continue to be severely limited and we will have to make do with a health care system that is a mere shadow of what we know it could be. In the meantime, my experiences suggest that one of the first investments we could make in order to improve long-term health care is to increase wages and benefits for those on the front lines, the nursing assistants. Thank you.

Chairman BAUCUS. That's a good final statement for the panel. The fact of the matter is, as I listen to all of you, all the other panelists, a lot of the problem—there are lots of problems. And one, Alan Cain has referred to just the increased cost of medical care in the country. It's rising at a rate faster than inflation, let alone for those who have the resources to pay for it. Then to make problems even worse, obviously those who don't have the resources face all of that, so it's a double burden, triple, quadrupled burden on them.

I think your statement, David, is accurate. That is that the quality of care in addressing primarily institutions is going to mean, by all standards should mean, the nurses aides and others are going to have to be compensated so they can provide the physical care, but, as you said, the emotional care. It's critical. But the long and short of it is, the general solution is that we're either going to have to expressly change, whether it be changes in the law, provisions in our tax laws, to help private insurers to provide better coverage and so forth, or whether it's through increased compensation through Medicaid and Medicare or some other program.

It all comes down to dollars. It's going—it all means that a very significant increase in resources is necessary to be devoted to health care in America. Today we are addressing primarily uncompensated health care and long-term health care. Certainly the additional resources are needed in those areas. I tend to think that we are going to have to work on the other end, though, and try to more efficiently distribute the dollars that are available to health care. That's a whole other subject and we won't get into that today.

Certainly your final point, Dave, is a good one. I frankly believe that this country has reached a point, for economic reasons, competitive reasons, environmental reasons, that we are going to have to devote significantly fewer resources to national security defense spending and instead devote those same resources to education, health care in America, productivity in America, fighting drugs in America. All that is really more important and more needed for more people. And frankly, I think that we have an opportunity here. It's my judgment that the elevation of Mikhail Gorbachev in the Soviet Union is potentially the most revolutionary positive change for peace in this century. I don't know what's going to happen, but certainly the potential is there. I think the Soviet Union knows, Gorbachev knows, and some others in the Soviet Union know that if they continue as much as they have been spending on military expenditure, that the Soviet Union is going to awaken in the beginning of the 21st century and is going to be a second or third in world power. They're spending too much for themselves and too little on their own country. We Americans are doing the same, and I think that consequently there's a golden opportunity for our two countries to reduce arms control expenditure, to adopt treaties limited not only to nuclear weapons, but strategic weapon expenditure, conventional arms reduction. It's very important that this country take advantage of that opportunity, people in Congress and others in America and all organizations, all of us as Americans take advantage of this so we two countries, the two largest military powers of the world, can begin to gear down virtually their military expenditure and gear up their attention to people in their own countries, and there's a good opportunity for us to do so, I think, now.

Until that happens and that begins to happen, and I think it will happen, I'd like to ask you, what is—I'll use this phrase—the right public/private mix, to use that awful phrase, between private health insurance and then Medicaid, Medicare, public programs? I'd like you to just touch on that, if you all could, please. Alan, I'll begin with you.

Mr. CAIN. Senator, I don't know exactly what to tell you when you ask for what is the right mix. I would suggest something in response to a question that was asked earlier, and there have been those in the past and the voices are continuing, and I'm not unmindful of them, that the way to handle all this problem is to adopt something like the Canadian system or a European system, since we are the last country in the world that has a fee for service medicine. The answer to your question is coming from that angle. You have heard ladies and gentlemen on this panel tell you what happens when you design a system in Washington, DC, that's administered in Baltimore——

Chairman BAUCUS. Don't say I designed it.

Mr. CAIN. That was much too broadly stated. When a system is designed in Washington to be administered in Baltimore, that is a principal factor in compensating the facilities that have been represented here today, simply because the population that is covered there wind up using those facilities to a considerable extent. What works in one area of the country doesn't work in another. You build in an automatic inefficiency. My suggestion would be the

answer is not a more extensive program. I would agree, and I've made the suggestion myself, that there ought to be more extensive funding of the programs that are in place.

But I happen to be involved in an organization where I get to talk on a routine basis with lots of Canadians, and I tell you, I don't profess to have expertise in that system, but I can tell the Canadian system is not a panacea for what we are seeing here. The trend figures I gave you here are also being experienced in Canada. The Canadians have controlled unit prices, but they have not controlled utilization. So all you are going to do with the Canadian system is shift this debate that goes on between Mr. Downer and myself in some instances, between doctors and ourselves, our company, between our customers and our company, into the Legislature and into the Congress where providers of service are in Canada lobbying their respective legislative bodies to increase the funding and increase the amount of money paid to hospitals and paid to physicians because it's inadequate.

Chairman BAUCUS. As I understand it, in Canada, at least with respective positions, and correct me if I'm wrong, the Federal Government decides the total number of dollars it's going to spend, say, on position reimbursement per Province——

Mr. CAIN. It's 50/50, Senator.

Chairman BAUCUS. You describe it.

Mr. CAIN. Again, I'm stretching a little bit because I didn't come prepared to talk about that system and I'm not an expert. The system is 50 percent by their Government, 50 percent by the Province, and the Federal Government exercises control over the expenditure the same way the Congress and Federal Government exercises some control over how we expend highway funds in this country. If you don't have a 55-mile-an-hour speed limit, then you don't get your highway fund. The programs are administered through the Province, that's the actual administering agency.

Chairman BAUCUS. Do the doctors in the Province decide among themselves what procedures are paid what reimbursement?

Mr. CAIN. As I understand that, the debate is, in their legislature, over how those procedures would be and the total amounts that would be available for reimbursing the physicians.

Chairman BAUCUS. Even though members of the Alberta parliament debate what fee should be for what——

Mr. CAIN. I can't tell you whether they get into a debate on that level, but I do know that—well, you can read it in the newspapers, and people I talk to up there, about the debates that go on, about what the level of funding will be for doctors and hospitals in Canada.

Chairman BAUCUS. What are some of the good attributes of the Canadian system that we could borrow? Any come to mind?

Mr. DOWNER. The primary attribute of the Canadian system is access. Everyone there does have access. However, one has to recognize that it does involve a certain amount of queuing up. And, like it or not, just because Canadians look like us, they don't necessarily think like the typical American who doesn't like to queue up, who wants everything right now. And I think that we have to recognize there is that difference once you cross the border. There's a substantial difference from Province to Province, as well. Alberta,

for example, has some modern hospitals, seems to have a system that's running relatively well, albeit there are waits for things that are not emergencies. If one goes to Quebec, one sees old, decrepit hospitals that have been run down, that there has been little put into them in the way of maintenance and upkeep and are relics of the 1920's.

So that it does vary, and I think one also has to look at another factor. That is the difference between the Federal Government in this country and the Federal Government in Canada. Canada is a confederation. There is a tremendously larger amount of power at the provincial level, so the relative amount that each Province puts in this direction will vary depending on the provincial priorities.

There's another thing going on now, and this has to do—maybe it's not an important point, perhaps it is, but just last week I was in Canada for a few days on a vacation and it's not generally known in the United States that right now 70 percent of the nurses in British Columbia are on strike. It is not generally known that in Quebec a major slowdown is going on in terms of the nursing profession in providing services, where no overtime is being worked and part-timers have limited themselves to 2 days a week. This is obviously going to affect access in those two areas. You do have to look at the fact that in Canada the climate is such that there are more strikes than there are in the United States, but these things are not generally reported in the American press.

Chairman BAUCUS. Do you have something you want to say?

Ms. HUGHES. I want to address the question about long-term care in terms of what a proper mix of public and private financing might be. You are probably aware there are several bills pending in Congress dealing with various kinds of financing for long-term care. The Mitchell bill, probably from the standpoint of those providing nursing home services, is the bill of choice, and I guess the reason for that is that basically what it does is it's a stop-loss type of measure; it kicks into place only after a person has been in a nursing home for 2 years. What it does is encourages as many people as possible to purchase private long-term care insurance.

The other thing it does is defines the risk so insurance companies are willing to offer long-term care and can offer it at a reasonable price, because the risk is limited to a certain amount of time as opposed to being open-ended. Basically you will always need an additional system for those who are unable to purchase insurance, although estimates from the Brookings Institute indicate that 60 percent of the elderly would be able to afford long-term care insurance under a system like the Mitchell bill because the cost of the insurance comes down when the risk is defined.

So from our standpoint it's a private and public partnership. Also, for those who can't afford the insurance, you are still looking at another system, Medicaid or some other system, to deal with the people who truly are poor. Medicaid is supposed to be a system for the poor, but in long-term care it's providing care for 60 to 70 percent of the people who need long-term care. It would take Medicaid back to the program for the poor and encourage those—and provide incentives for those who could purchase insurance to do so. Employers should be encouraged, also, to at least offer that type of insurance.

Chairman BAUCUS. I assume that Canadians, on the per capita basis, pay more taxes for public health care coverage than do Americans. I see you are nodding, Alan; is that correct?

Mr. CAIN. Once again, the figures I don't have to give you, but I would say the gentleman who related his experiences in Canada experienced a lot more than $68 per cost, and the Government picked it up.

Chairman BAUCUS. Canada subsidizes more than we Americans do as a general rule. So it seems to me that if there are more public resources to solve some of these problems—there are really two sources. One is to divert some, as I mentioned earlier, national security military dollars. That's one source. The other is additional taxes. If we really have to and are forced, to some degree, to go to the second source, what, in your view, is the best way to do so, payroll taxes, income taxes? What do we do? If Medicaid is going to provide more, if Medicare is going to provide more, what financing mechanisms seem to make some sense? Even if we have changes in the tax laws to provide for long-term health care insurance, that's general revenue, so I'm just curious as to thoughts any of you may have as to how we begin to finance some of these additional services.

Ms. HUGHES. I'll take a stab at that. I would suggest that the first thing that we need to do, and I think you mentioned it earlier, is provide—is be sure we are providing the services and paying for services in an efficient manner. I think there are savings on the regulatory side that could be made before I would suggest any new taxes. Our facilities——

Chairman BAUCUS. Regulations?

Ms. HUGHES. The costs in our facilities are going up because of paperwork and regulations that are not providing 1 minute's care to our patients.

Chairman BAUCUS. I hear that and I understand what you are saying and I essentially agree with you. I don't think that's going to solve the problem. If we are honest about this, we heard the earlier panel, there are a lot of people in America who have those same financial problems, and since we're honest about it, it seems to me we are going to have to hit this thing directly. Hitting our regulations, that's a start, but there's going to have to be more to it than that. Maybe partially the Canadian system, I don't know. It's going to have to be more.

Mr. DOWNER. I think the only way to deal with it in a tax system is somehow deal with it through the income tax process. The payroll tax hits only those people who are employed and the employers of those people. However, when one looks at the small proportion of the Social Security amount that goes for the Medicare Program, it really would cause very small increases in the income tax to adequately fund this. But I would agree with those who say there ought to be some reprioritization within the Federal Government as to what, indeed, is important. And I personally think higher taxes are going to have to come even though we might look at a system like Canada's, because in Canada the taxes generally are higher as a percentage of income than ours are, as is the case in most developed countries.

Chairman BAUCUS. What about employer-mandated benefits? That's going to hurt a lot of Montana businesses more than other States' businesses. We are a small business State, lots of small employers, and I've forgotten, one of you, it was Alan, talked about the premiums in it was Sidney or several communities in the State, small communities, small employers, fewer employees. Big companies can buy health insurance. First of all, the Tax Code, unfortunately, is against the self-employed, but how are we going to devise a system that doesn't disproportionately hit small business, hit Montana?

Mr. DOWNER. I think you have to deal with it on the basis of tax credits for the smaller employers in some form or another. I'm not an expert on taxes, but it isn't realistic for those who are larger employers to be funding employee health insurance, albeit self-funded or through insurance, and have a whole group of people out there who are not paid for. And speaking as a hospital provider, one of our great problems is this whole group of the working poor, the people who are uninsured who come to us and suddenly are faced with a bill for $4,000, $8,000, $12,000, more than that, and frankly, as a charitable institution, as a hospital worthy of the name, I think we are going to give that care, but we can't give it indefinitely without these people being able to pay. It may be absolutely necessary to mandate employer coverage, but there has to be some way to help the smaller employer in subsidizing.

Chairman BAUCUS. Another problem, that's just the paperwork. It was interesting to me when someone mentioned the problem of paperwork and the response from the audience here. It's paperwork the patients have to go through, it's paperwork the institutions have to go through, the doctors have to go through. It's incredible the amount of paperwork. A, the cost of paperwork; B, it's time taken away from what you should be doing; C, it breeds distrust, which is not always helpful, to say the least. And I've heard one benefit of the Canadian system is maybe some queuing up, there's a lot less paperwork. So it seems we can devise a system here that can make some sense, everyone is treated about the same, and it's some way to get rid of a lot of the paperwork.

I think the fellow that talked earlier, Harry Higgins, mentioned that it sounded like there wasn't a lot of paperwork involved in his car accident in Canada, it was taken care of, not a lot of questions asked and so forth. It seems to me we have to have a system that has a lot of those attributes put in it. Do any of you have any other statements you want to make, any points? Anybody say anything outlandish that should be addressed? Thank you very much.

STATEMENT OF JAMES R. ESKRIDGE, GENERAL MANAGER, SUN RIVER ELECTRIC CO-OP, INC., FAIRFIELD, MT

Mr. ESKRIDGE. I appreciate the time you are affording me here today. My name is Jim Eskridge and I'm general manager of Sun River Electric in Fairfield, MT. I'm probably one of the few people here that isn't directly related to the medical industry, but I've become more and more involved through the efforts of some economic development and also through some personal interest. I live in Fairfield, MT, a town of about 600 located about 35 miles north-

west of Great Falls. I've requested time before your committee because I'm deeply concerned over declining health services and rising health costs in rural America and particularly rural Montana.

As a major employer in our community, we've seen medical insurance and related costs increase by more than 130 percent in just the last 3 years. Additionally, we have seen a definite rise in the instability of our primary and secondary providers in our community. We have seen four physicians come and go in the same 3-year period. My primary concern for our community and others like ours all over America is the breakdown of primary and secondary health care services as a direct result of outmigration, low per capita income, and high rates of uninsuredness. These problems are compounded by lower Federal expenditure per capita for health care, including Medicare payments to hospitals demonstrated to be 30 to 35 percent lower for rural secondary hospitals than for our urban counterparts.

Because of high rates of uninsuredness, usually resulting from chronic diseases or financial inability to purchase insurance, early treatment by primary physicians is neglected or postponed. The result is higher costs to people, insurance providers, and government entities. In short, the system is broken down. The family doctor concept has fallen to more expensive specialists and tertiary care. This, compounded by the high cost of liability and malpractice insurance, has resulted in an inability to attract highly qualified family practitioners and physician assistants to our smaller communities, causing instability or closure of our clinics and our small secondary hospitals.

I'm here today because I believe we have the means at our disposal to turn this problem around. It's the same solution that rural people have been using for years to resolve the problems created by low population densities, high costs, and low incomes. The institution I refer to is the rural cooperative. Men, women, and communities joining together to accomplish what we could not do individually. Cooperatives have long had proven and successful track records as mechanisms for accomplishing what seemed, at first glance, to be nearly insurmountable tasks. Cooperatives are understood in rural America, and even more importantly, they are accepted.

In our community today, patients and business leaders are becoming more and more frustrated by increased medical costs at the insurance level and in some cases at the provider level. At the same time the physicians, the G.P.'s [general practitioners], and family practitioners are frustrated by the dilemma of wanting to meet the needs of the patient, but caught up in the medical system more interested in the bottomline than in the patient. And I think that Dr. Coombs this morning addressed this to some degree. I think you've heard other people addressing this. The physicians are getting very frustrated in rural America. Not only are they unable to provide the types of services that they've been taught to provide, as a result of high cost liability insurance, malpractice insurance, they're becoming just extremely frustrated with a system that's more interested in maintaining the status quo at any cost rather than change to more adequately meet the needs of individuals in small communities. I don't mean to be as critical as this sounds of

the health community, but I think there are far too few innovative methods coming about. It reminds me of a person drilling a well and if they don't hit water at 100 feet, they drill down another 100 feet and then maybe another 100 feet and another 100 feet instead of taking the idea of maybe they should move over and drill another well.

Out of these frustrations has come the idea in our community for a health service cooperative which would be responsive for the needs of individuals, the doctors, and the rural hospitals. A service cooperative different from any other existing today, and yet the same in its basis, the grassroots, the people that it would serve. A medical service organization truly of the people, by the people, and for the people. An organization of individuals joined together for a common purpose, good rural health care at the lowest possible cost. It is our belief that such an organization can be established to these ends. An organization which would focus the medical services within a given geographical area in such a way to promote good, stable primary and secondary health care at reasonable costs to the patient. At the same time we believe such an organization could provide autonomy and reasonable rates of return to physicians and hospitals.

In our community we are working diligently to form a rural health services cooperative. The long-term goals of that organization are to establish a strong, well-managed cooperative dedicated to providing the good comprehensive referral health care at reasonable costs, to focus community health care to the betterment of the individuals and the community, and third, to improve local economies by supporting and maintaining local primary and secondary health care facilities.

These long-term goals would be accomplished by meeting the following short-term objectives: One, by providing members insurance coverage at reduced cost through economies of scale; two, by providing members reduced medical costs through affiliated family practitioners and family physician assistants; three, to provide primary health care facilities cooperatively owned and operated; four, provide secondary health care and intermediate care facilities cooperatively owned and operated; five, provide reduced drug costs through affiliated preferred providers; and six, by providing cooperatively owned and operating ambulance service to the community; and finally, seven, by providing education through preventive health care programs currently inaccessible to many rural residents.

Although cooperatives have long been the solution to many rural America's needs, they have not gone unopposed. Many people believe they are a socialistic animal and as such has no place in the free market world. It is regrettable that some within the insurance and medical communities feel just the same way. It is my hope that in time these entities will see rural medical cooperatives as a great opportunity and not a threat. For myself and my community, we ask that this committee take a hard look at health service cooperatives.

We ask for your support in Congress. Recently Congress was presented with a budget containing an additional $500 million for

health care. We believe health care cooperatives could be a good mechanism for channeling funds to where they are needed most.

Cooperatives have proven their usefulness in the past and the present through successful programs such as rural electric cooperatives and the rural telephone cooperatives. It is our belief that a rural health service cooperative program could be just as successful. We ask that you support this for our small project, as well as for a national program. I thank you for your time.

Chairman BAUCUS. Don, you're next.

STATEMENT OF DR. DON ESPELIN, CHIEF, PREVENTATIVE HEALTH SERVICES BUREAU, MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SERVICES

Dr. ESPELIN. I really appreciate being here, it's a genuine pleasure to be here. I want to thank you and your select staff for inviting me to participate in these proceedings. We are going to shift gears a little bit. I'm a pediatrician and on the other end of the spectrum of what we've been talking a lot about today, but not completely. I'm the bureau chief of the Preventive Health Services Bureau at the department of health and environmental sciences in Helena for the State of Montana. I spent 20 years in private practice and went into public health after being disabled from heart disease.

The problem that we see in the pediatric aspect of what we are talking about is infant mortality, as mentioned by Dr. Coombs earlier today; 40,000 babies a year died in this country, half of those unnecessary and all under 1 year of age. Montana adds about 100 to 120 to that group every year; half of that is preventable. The rate for Montana in the neonatal area, that is those babies that die under 1 month of age, in Montana we are usually No. 1 or No. 2 in the Nation. In a postneonatal rate that's bothersome in Montana. Our rate puts us among some of the five worst States in the United States. The rate of postneonatal mortality is practically unchanged over the last 30 years. As a pediatrician, to me that is an obscenity. When you consider the advances we've made in other areas of medical care, we should be able to do better with our infants.

In Montana we've developed a project called the MIAMI project. By the time we got through the legislature, every legislator knew what that meant. It has five legs to the program, first of which is public education, and we adopted a program that was done in Utah called Baby Your Baby. It's going to cost us about $280,000 for 2 years. We hope to split that up with four sponsors. One of those will be the State of Montana, both my programs in the health department, plus the social and rehabilitative services and other parts of that, and then we are shooting for three private sector promoters for that program. It has four 30-minute documentaries, 105 radio spots. It's a multimedia event with TV, radio, newspapers. The newspapers have special sections in them that precede the documentaries on TV.

Another leg of the program is the infant mortality review, and this is a review program that takes place out of hospital. The babies that die in hospital are reviewed and we know why those babies die. It's the babies that die out of hospital that we are inter-

ested in. We want to pick target communities in the State and look at those babies and see what the common factors are. Coupled in that review are late fetal death and low birth-weight babies to find out what the reasons for those are.

Our origin plan was to focus on 16 communities in the State and put a nurse practitioner in all of those 16 communities. Inadequate funding and a variety of other reasons have prevented that from happening. The other part of that was doing coalition building in the community. Such has been discussed by Mr. Eskridge just previous to my testimony about building a coalition in the communities to get a health program in place, and this would have been obviously for maternal and child health. Low birth-weight programs are in progress in the State already. It would have been an additional part of our MIAMI project. Access Links has been running here in Missoula for a couple years. It's first year it cut the low birth-weight in that population by one-half. A significant improvement in health care.

A lady from a small town in Montana was brought into one of our low birth-weight programs. She had every high-risk factor that a person can have in a pregnancy except diabetes. She weighed about 300 pounds, she had twins on board, was in early labor, about 24 weeks gestation. Had she delivered at that time, we would certainly have been looking at some long-term neonatal intensive care costs for those babies. She delivered at term and delivered at a hospital nearby and has done well with her term babies. There was no neonatal intensive care costs with those babies. She has been motivated and finished her education and got a job and is paying taxes.

The bottomline with all this is with some fairly easy applications, we can cut infant mortality and low birth-weight in half. Just in Montana and dollars saved in health care costs, short and long term, we are looking somewhere between $20 and $40 million a year in savings. I'm going to include some other testimony, the high cost Medicaid baby study that SRS has performed. It's too lengthy to read here.

The fourth part is Medicaid reform. We have got eligibility at 100 percent of the poverty for the State of Montana into this law. One of the things we did not get that we need is continuous eligibility. Once a woman is on Medicaid, she goes on and stays on Medicaid throughout the course of that pregnancy. Also, we need a proactive attitude for Medicaid, and we are seeing that happen. We are developing an interrelationship between health and Medicaid to see that happen. The umbrella of all this is an advisory or oversight committee that's appointed by the Governor to review this and report back to the legislature in 2 years whether or not we can do the job.

Now, I'd like to leave the infants for 1 minute and talk about some of the things that have been brought up here today. We need to foster a sense of community. We need to put in place mechanisms that can do that, and to do it it takes committed, passionate people to get that job done. Take the shakers and movers into the communities and move them on to building coalitions to get things done. Just as referenced to a few minutes ago, we need to develop a comprehensive national health policy. This Nation does not have a

health policy, as such. It has bits and pieces scattered all over, there's no coordination. The State of Montana also needs some kind of health committee on disease prevention. I go around the room here today and I see cigarettes in people's pockets. Montana is the best State in the Nation for quitting smoking.

Chairman BAUCUS. Really? That's great.

Dr. ESPELIN. But why is it that we can still buy that most lethal drug in a drugstore? Why is it that we don't do something about a drug that kills one-sixth of the people in this country? A rhetorical question.

Another rhetorical question, to get on to another disability. We had a woman present here as a quadriplegic earlier today in an automobile accident. If she ever develops a decubital ulcer, it can cost $100,000. Preventing secondary disabilities ought to be a leading part of our health care process in controlling long-term health costs.

Another rhetorical question, why is it we can start a car without having a seatbelt in place? We ought not to be able to start our cars without having a seatbelt in place. Why is it that all cars are not equipped with airbags? We could ask these questions all day, and I know you know them as well as I do and I'm not going to take your time up to go into this any further.

Montana has four genetics programs for small grains, one for kids; 20 percent of the population needs genetic counseling in one form or another. Major efforts should be placed in that. You had a woman here today that needed genetic counseling. It probably wasn't available when she needed it, but it is available now. I want to thank you again for allowing me to come and talk to you.

Chairman BAUCUS. Thank you, Don. Very briefly, why are we fifth in the Nation in infant mortality, neonatal mortality?

Dr. ESPELIN. We are among the five worst in postneonatal infant mortality.

Chairman BAUCUS. Why?

Dr. ESPELIN. We really don't know why, and that's why it's so important to get into that infant mortality review and find out why. We see a lot of deaths through the birth certificates listed as SIDS death. I don't believe that. I'm a pediatrician and I believe there are other things happening there.

Chairman BAUCUS. Patricia.

STATEMENT OF DR. PATRICIA HENNESSY, ST. IGNATIUS, MT

Dr. HENNESSY. I want to thank you, Senator Baucus, for bringing these field hearings to Montana and braving the thorny problem with comprehensive health care coverage. I've been given 5 minutes to present a viable solution to the problems posed in the last 2 hours. It would be ludicrous to attempt to do so if it weren't so simple. The idea is as straightforward as the Montana mountains and the details of implementation just as straightforward once we make the commitment.

The time has come for a national health plan. One that is universal, that covers everyone. One that is comprehensive, one that covers all medically necessary services and publicly dispensed. We have heard poignant testimony today that by the time the stream

of public health care dollars trickles down to us here in Montana, it's too little and too late. We need an upstream solution. A solution in which public administrative dollars are not spent excluding those in need, but rather including everyone. And we needn't reinvent the medicine wheel. A comprehensive plan similar to the ones enjoyed by our neighbors in British Columbia and Alberta can work in Montana, and, with modification, perhaps throughout the United States.

I came to Montana 13 years ago with my husband, also a physician, to begin a community-based rural health clinic funded with a half million dollar grant from the Robert Wood Johnson Foundation. Called the Rural Practice Project, we were 1 of 13 sites nationwide that sought to bring comprehensive health care to rural areas where financial and geographic barriers to health care created a community need. The clinic was located in St. Ignatius on the Flathead Indian Reservation. Almost half our patients were native American people whose care was largely publicly financed. Another significant portion of our patients were self-employed farmers, ranchers, loggers, and their families. These largely uninsured, solid Montana wage earners often were sorely pressed by the costs of even their noncatastrophic medical costs and often went to extremes to manage their medical bills. It was not uncommon for a patient to want to barter goods or services in exchange for O.B. [obstetric] services; maybe some handmade furniture, 1 year's worth of chickens, or a fencing jobs on 30 acres. Others kept their health costs low at risk to their own health. I remember distinctly a carpenter who left the hospital less than 24 hours after his badly fractured femur was plated because the cost of his first hospital day was as much as he could afford and he was too proud for charity.

For the last 5 years I've worked as the physician supervisor for the R.N./nurse practitioners who staff the Missoula City/County Health Department Clinic for the medically uninsured. In 1988 this clinic treated over 5,000 people with no advertising, save word of mouth. Today this clinic remains financially unstable. The recent findings of a communitywide task force here suggest that despite a clear-cut need and a population that's needier, there is no clear-cut financial support for this clinic locally.

From these vignettes and from a multitude of others you've already heard, you must undoubtedly see that this country is in the midst of an epidemic, the medical event called underinsurance, which affects 37 million of us, almost one person in five, and is growing daily. This problem cannot be treated with a patchwork quilt approach which merely modifies our existing nonsystem. It's time to face the problem and offer Montanans, and all Americans, the kind of comprehensive health care coverage every developed country, except South Africa, offers it's citizens. The question is no longer if, but when.

I would like to propose Montana and Montanans as a pilot State, likely one of several demonstration projects for the national health plan we know is coming. In the time allotted, I can barely paint the broad outlines of such a plan, but you each are certainly aware of such proposals. As a member of the Physicians for a National Health Plan, I support the proposal outlined in detail in the January 12, 1989, issue of the New England Journal of Medicine. As

suggested in this plan, I would request that the Commission select a small number of States for pilot projects and start with Montana. Montana is typical of the rural Northwest with its financial and geographic barriers to health delivery and access. Our State plan would be administered by a State health payment board based in Montana. All the important players are ready, the hospitals, the physicians, the businesses, and most importantly, the everyday working Montanans.

A Montana program based on the principles of universal comprehensive care would offer the potential for saving the moneys we now spend assisting the problem premature infants whose mothers were unable to get access to prenatal care that would have prevented these costly programs in the first place. We would save one-half the total Medicaid expenditures that are now used to determine eligibility, and we could appropriately spend the moneys for long-term care by designing programs which fit the unique needs in Montana instead of complying with multiple guidelines designed 2,000 miles away.

A Montana comprehensive plan would keep the doctors happy by protecting our practices from the intrusion exerted by insurance companies and our third-party payers and eliminating this bureaucratic interference in our clinical decisionmaking. Overhead costs, especially office billing costs, would decrease, and there exists a potential for a vast decrease in medical liability claims. Our Canadian cousins experience only one-tenth of Montana liability claims. It would keep our businesses happy. This State is at a critical period of economic development. The other current health plans under consideration would pass much of the costs directly to employers. We've already heard that this would devastate much of Montana's small marginal businesses. A Montana plan would keep hospitals happy. The current climate has forced health care institutions to compete like fast-food restaurants for the health care dollar. A Montana health plan would save dollars in public relations, as well as capital expenditures, administration, and the overhead necessary to meet the guidelines of multiple third-party payers, and would eliminate the hospitals' thorny problems of uncompensated care.

Most of all it would keep Montana citizens happy. These last years have been very difficult for those of us in America's interior. While your Commission and its members cannot change the multifaceted problems of our business climate and outlook and put dollars in our pockets, as one gentleman said, a comprehensive universal health plan will offer Montana citizens an incalculable sense of relief and free all of us to rise to the challenge that tight economic times create without the specter of anxiety and dread that every uninsured household faces when an injury or illness poses potential financial catastrophe.

In Montana's centennial year, it's time to remember those who forged this State out of the frontier. They did not lack for creative ideas, nor for the ability to change those ideas if and when the needs dictated. Most importantly, they did not lack the will to put those ideas into action, even when those ideas were not yet perfected. This has been Montana's and America's heritage. Now our country's creative energy can offer a plan for comprehensive

health coverage perhaps not yet perfected, but ready to be implemented. It lacks only the will of our policymakers to make it happen. I ask that you bring this message back to the full committee. Times have been difficult, we believe we have a viable solution, and we are ready now to try it here.

STATEMENT OF STEPHEN C. STANLEY, ADMINISTRATOR, HORIZON LODGE RETIREMENT CENTER AND ASSISTED LIVING, CONRAD, MT

Mr. STANLEY. I'm Steve Stanley representing Horizon Lodge in Conrad and the Montana Association of Homes for the Aging. I've been asked to testify about an innovative program here at Horizon Lodge we are currently providing for senior citizens, disabled, and handicapped. I feel that ours is not an innovative program, but a necessary one.

While administering and working in nursing homes, I witnessed admissions of residents that did not need nursing home care. Some only needed a little extra help or support in order to maintain themselves at home. They did not need to be institutionalized. When placed into an environment with individuals who required the skilled or intermediate care because of acute problems or inevitable death, many of those who hadn't needed nursing home care soon did. The atmosphere of the nursing home and the knowledge that this might be the last stop before the cemetery helped to deteriorate the health and the outlook of many of those who otherwise, in another place, would have had some good years left to their life to be lived with dignity.

Horizon Lodge is a nonprofit 84-unit apartment complex owned by the nine churches in town with a HUD 236 mortgage and section 8 set aside for 25 low-income apartments. We are located in Conrad, MT, with a population of about 3,500 people. Our building is 15 years old and at present we have 100 percent occupancy.

After accepting the challenges of Horizon Lodge, I again saw elderly or disabled sent to a nursing home because as a retirement center, we couldn't offer these added services. The consequence of studying this phenomenon for 2 years, the Horizon Lodge board of directors decided we should offer assisted living, a form of personal care. We began our program with 18 units, out of our 84, of assisted living. Our program provides 24-hours-on-duty nurses aides. No nurses, the State law does not allow us to have nurses. The resident assistants, as we refer to them, help provide the extra services necessary to maintain these people in their own apartments. Not in rooms, in their own apartments. Staff help with medication reminders to make sure the medication is taken at the proper time and in the proper dosages. The resident decides who will set up their meds, as the law prohibits us from doing that. A resident will generally request a third party or contract with a nurse to do this. We do have a volunteer nurse in our building who does this for those who want it.

Our services include doing the laundry, helping with housework, assistance with bathing, dressing, taking them to and from the central dining room if they need that help, and activities and taking them for walks or exercises and anything else the resident, the

doctor, or the family feels needs to be done to maintain this person in our assisted living units. The family members can stay with the residents, can put rollaway beds into the apartments, and actively participate in all programs and have a real say in the care of their family. Volunteers help us in many ways. All participating residents are, however, encouraged to do as much as possible for themselves, not only for better health, but also to maintain independence and dignity. Other residents living in the retirement complex can utilize any part of the assisted living service as they need it on a prorated basis.

The fee for such a program at Horizon Lodge, assisted living, three meals a day, and rent for the apartments, which includes heat, lights, water, and air-conditioning, is $839 a month. The cost for this same service at an intermediate or skilled care institution is approximately $2,100 to $2,500 per month in the State of Montana.

And it's not necessary for many of these folks. On Friday, last Friday, we had a lady return from Deaconess Hospital in Great Falls to her apartment. She fell and broke her hip in November. The hospital was familiar with our program and said the lady could maintain herself now back at her apartment under our assisted living program. In mid-May another resident with a fractured hip returned to her apartment and came from our extended care section of our hospital and nursing home in Conrad. Without the assisted living program, both would be in a nursing home needlessly. Stroke victims with only partial use of their limbs needing only a little help with their meals or laundry, heart patients who require supervised exercise and proper diet, physicians and hospitals are referring people like this to us because of our program.

Our program is not Medicare or Medicaid reimbursable, even if it is less expensive than nursing home care. If those Montana Medicaid residents requiring only personal care could be serviced by places like ours rather than placement in a nursing home, the State of Montana would save $4 million just this year.

At present, the average age at Horizon Lodge is 85 years old. We have full occupancy and 84 on the waiting list to move in, which I'm confident to say is partially due to our assisted living program. Our waiting list is made up of people across the United States representing 27 different States. We are trying to build 53 more apartments for assisted living respite care and adult day care center at an approximate cost of $4 million. Our plans are almost to completion, but because we are nonprofit and under HUD, we do not have the capital to build or to get to that stage as quick as we need to.

Fort Benton and Roundup are initiating their program of assisted living to augment their caring for the retired center residents. However, HUD is not encouraging their programs. There are other personal care homes in Montana needing financial help for their residents.

In summation, let me say assisted living or personal care is long-term care. It is financially feasible, even though startup costs are high. Over the long range it will save money both for residents of such facilities and the taxpayers in the State of Montana. It will provide a better quality of life for our citizens as they age in place. Living as independently as possible and maintaining their personal

dignity in a noninstitutional program will add new meaning to their lives. I feel this is a viable alternative to nursing homes for those who do not need full-time nursing service. Nursing homes do have their place in the spectrum of long-term care, but only at the time when it is necessary.

The elderly are a proud group, I've worked with them for many years. They want to be able to take care of themselves both physically and financially. They know that going to a nursing home will wipe out their funds and then welfare takes over. If they can support themselves as much as possible, they feel they are doing their share. Assisted living for those who are aging is one answer and is one that must be embraced by the government, both State and Federal, as one of the solutions in health care. And it must be addressed soon, as we are all growing older and will need these very services in the very near future. Thank you fo letting me testify. Thank you.

[The prepared statement of Mr. Stanley follows:]

ORAL and WRITTEN TESTIMONY of Stephen C. Stanley of Horizon Lodge, Conrad, MT
Presented June 28, 1989 Missoula, MT:

The Honorable Max Baucus, Commission members, Ladies and Gentlemen:

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Horizon Lodge is a non-profit, 84 unit apartment complex owned by the 9 churches in town with a HUD 236 mortgage and section 8 set aside for 25 low income apartments. We are located in Conrad, MT with a population of about 3500 people. Our building is 15 years old and at present has 100% occupancy.

After accepting the challenge of Horizon Lodge, I again saw elderly or disabled sent to a nursing home because as a retirement residence, we could not help them.

The consequence of studying this phenomenon for two years, the Horizon Lodge Board decided we should offer "Assisted Living", a personal care type service.

We began our program with 18 units or beds of assisted living. Our program provides 24 hour on duty nurse's aides - no nurses, as state law directs. The Resident Assistants, as we refer to them, help provide the extra services necessary to maintain these people in their own apartments. They help with medication reminders to make sure medication is taken at the proper time and in the required dosages. The resident decides who will set up their meds, as the law prohibits us from doing this. A resident will generally request a third party or contract with a nurse to do this. We do have a volunteer nurse available for those who choose that route.

Our services include: doing the laundry, helping with housework, assistance with bathing, dressing, to and from the central dining room and activities, taking them for a walk or for exercise and anything else that the resident, doctor, or family feels needs to be done. Family members can stay with the residents, actively participate in all programs, and have a real say in our care.

All participating residents are, however, encouraged to do as much as possible for themselves not only for better health, but also to maintain independence and dignity. Other residents living in the retirement complex can utilize any part of the assisted living service as they need it, on a pro rated basis.

The fee for such a program at Horizon Lodge, assisted living, 3 meals a day, and rent for the apartment, which includes heat, lights, water, and air conditioning, is $ 839 per month. The cost for this same service at an intermediate or skilled care institution is approximately $ 2100 to $ 2500 per month and not necessary for some folks.

On Friday, we had a lady return from Deaconess Hospital in Great Falls to her apartment and our program because the Hospital was familiar with the program and the lady could still maintain herself. In mid-May, another resident with a fractured hip returned to her apartment and our program from Extended Care in Conrad for the same reasons. Without the assisted living program, both would be in a nursing home needlessly.

Stroke victims with only partial use of their limbs who need only a little help with their meals or laundry, heart patients who require supervised exercise and proper diet...Physicians and hospitals are referring people like this to us because of our program.

Our program is not Medicare or Medicaid reimbursable - even if it is less expensive than nursing home care. If those Montana medicaid residents requiring only personal care could be serviced by places like ours, rather than placement in a nursing home, the state of Montana would save approximately $4,000,000 this year.

At present, the average age in Horizon Lodge is 85 years old. We have full occupancy and 84 on the waiting list to move in, which, I'm confident to say is so large due to our Assisted Living program. Our waiting list is made up of peopole across the U.S.

We are trying to build 53 more apartments for Assisted Living at an approximate cost of $4,000,000. Our plans are almost to completion, but because we are a non-profit and under HUD, we do not have the capital to build or to get to that stage.

Fort Benton and Roundup are initiating their program of assisted living to augment their care for the retirement center residents. However, HUD is not encouraging their programs.

In summation, let me say Assisted Living or Personal Care is Long Term Care. It is financially feasible, even though start up costs are high, over the long range, it will save money both for residents of such facilities and the taxpayers. It will provide a better quality of life for our citizens as they age in place. Living as independently as possible and maintaining their personal dignity in a non-institutional program will add meaning to their lives.

I feel this is a viable alternative to Nursing Homes for those who do not need full time nursing service. Nursing Homes do have a place in the overall picture of long term care, but only at the time when it is necessary.

The Elderly are a proud group. They want to be able to take care of themselves both physically and financially. They know that going to a nursing home will wipe out their funds and then "welfare" takes over. If they can support themselves as much as possible, they feel they are doing their share.

Assisted Living for those who are aging is one answer and it is one that must be embraced by the government - both state and national - as ont of the solutions in health care. AND it must be addressed soon as we are all growing older and will need these very services in the future.

I would like to have this entered as a continuation of my oral testimony:

Other problems and possible solutions I see in Long Term Care are as follows:

1. Nutrition - Nutritious meals are very important to the health of our citizens. The Title III Older Americans Act providing congregate meals and Meals on Wheels needs to be expanded. Having nutritious meals will save health care costs and help prevent the debilitation of our older Americans. One good meal a day does not provide the food requirements that are necessary. Food is cheaper than medical care.

2. Medicare and Medicaid Waiver -
Must be extended to cover Personal Care and not just Home Health Programs. Home Health serves its purpose, but the time comes when more care is needed. Personal Care will take over in the plan of continuum of care. This is less expensive and enables dignity and enhances the quality of life.

3. Rural Hospital funding -
Under current DRG's and rising health care costs, the rural hospitals are closing. True enough, greater expense is experienced in operating a rural hospital, but the "home town" care and having family and friends nearby does speed recovery in most cases and will save money over the long range.

4. D.R.G.'s -
This plan is a failure. Recoveries are based on individuals not just care. In many instances, before the patient ever enters the hospital, their condition is deteriorated so much that recovery is slower. Often I have seen patients returned home that were in a worse condition than when they went into the hospital.

5. OBRA rules & regulations -
Congress cannot know what rules and regulations were put into this Act. Had they known that many of these regulations are unworkable as well as financially unfeasible, they wouldn't have gone ahead with OBRA. Our legislative branch should take another look at this.

6. Medicare forms -
As simple as this problem sounds, many elderly do not understand these forms and when the doctors won't submit the claim, the patient is at a loss with how to file their own Medicare claims.

7. Federal Housing for Elderly -
Supportive services, or therapy services are not allowed at present in federal housing programs. These are integral parts of service to these residents, and will provide better living conditions for those in these housing units. If we could offer more of these services, I'm sure less would need nursing home care as soon as some are being placed. We need these services now. Each day that passes, more and more unnecessary placements are being made to nursing homes.

8. Psychological services -
Too often, those elderly with psychological problems are being forced to drug therapy under Medicare. Over-medication is one of the more significant problems in the elderly population. They need the services of a counselor to help them with their problems, not drugs. Over medication is not limited to the psychologically impaired. Many hospitalized or institutionalized elderly and handicapped are never given the opportunity to "Just say no" to drugs. It seems the prevalent attitude among those responsible for providing care is 'the more medication, the less care required'. Drugs are not only unnecessary, but also costly. Common sense should dictate a remedy for this problem.

9. Area Agencies on Aging -
Ten of Montana's Area Agencies on Aging lost funding due to the State Aging Services Bureau transferring funds from the Area Agencies to the Tribal Area Agency because of their interpretation of the Older Americans Act Amendments of 1987 making the tribes eligible for both Title III and Title VI funding. According to a news release from the Select Committee on Aging, it was reported that the House has passed House Resolution 2072 which reprograms $3.3 million in FY'89 unexpended Older Americans Act funds to cover the shortfall in Title VI of the Act. This bill was the House's response to concerns of the 184 tribes being eligible for Title VI instead of 136. Unexpended funds in the past were reallocated to the States to allocate to all area agencies. Now the ten area agencies in Montana will be losing the opportunity to recapture some of their loss. The area agencies agree that Congress should make additional monies available for additional clients, but the monies shouldn't be taken from those who have already been cut. A recommendation from Montana's Area Agency on Aging Directors Association was to increase the allocation to minimum funded States. This recommendation has been presented to Senator Baucus and Senator Burns, but the Area Directors Association has not, at this time, received a response to this recommendation.

10. Medicaid and Community Care Options -
I encourage passage of S785. I feel this could be expanded to cover Personal Care. Under this bill, Functional limitations refers to problems such as difficulty walking, or feeding oneself or needing assistance to use the toilet. It should also include medication reminders and home chore services. Such an expansion would help keep American citizens from having to go to nursing homes to get the help which community based Personal Care could offer.

Committee members, as you know, there are many problems that are developing in long term care and they are coming more quickly because of the aging trend. We need solutions now. Call on those in the field of elderly care, not the buroaucrats, to get the information you need to make these tremendous decisions that are facing you and your fellow Congressmen and Senators.

Listen to those of us in the field, working daily with health care problems. We are working with the guidelines that have been established but are becoming unworkable and antiquated.

Thank you for this opportunity to speak and write regarding some of the issues I, and many of us in the U.S. who are working with the elderly, now face. If I can be of further help or you should need more information, please do not hesitate to call on me.

Chairman BAUCUS. OK, Jane.

STATEMENT OF JANE ANDERSON, DIRECTOR, AREA 5 AGENCY ON AGING, ANACONDA, MT

Ms. ANDERSON. Senator Baucus, ladies and gentlemen, my name is Jane Anderson, director of Area 5 on Aging in Anaconda, MT. Our agency serves six counties in southwestern Montana. The Area Agencies on Aging were created by the Older Americans Act in 1973 to help the elderly in their own communities maintain the highest quality of life with independence and dignity through a prescription of services developed at the local level through planning and coordination. Of the 120,000 individuals in Montana over the age of 60, the Montana Area Agencies on Aging serve 65,000 with a variety of services, which include transportation, nutrition, homemaker chores, health maintenance, senior centers, outreach information and referral, legal assistance.

Unfortunately, area agencies are not funded at a level that allows them to address the full scope of needs for long-term care. When long-term care is discussed, many people immediately think nursing home. Long-term care is reference to a continuum of preventative medical, therapeutic, rehabilitative supportive and social and personal services needed by individuals who have lost some capacity for self-care. Long-term care is more than nursing home care, it includes community-based and inhome services. Only 5 percent of the dependent elderly receive their care through formal paid services. In fact, 80 percent of long-term care takes place in the home with older persons depending on informal help from family members for assistance with daily activities such as shopping, bathing, housekeeping, and dressing. Women comprise about 72 percent of the caregivers, with 29 percent of the care from adult daughters and 23 percent from wives. The other female relatives comprise the balance.

In 1972 when we started programs for the elderly in Anaconda, the Anaconda copper smelter was operating and jobs were plentiful. The elderly were assured of having family members available as primary caregivers. However, in 1980 the Anaconda smelter closed, and because of the economic conditions of the area, the young people were forced to leave to seek employment. From 1980 to 1987, Anaconda lost 19.4 percent of the population. The elderly who owned their homes or were situated in other housing were reluctant to migrate. Many of the elderly in the area have lost the availability of unpaid family caregivers.

Public programs are needed to address the concerns of both individuals in need of care and their caregivers. Long-term services should be available to all those who need them, regardless of age or income. A national long-term care program should provide a comprehensive range of facility-based, community-based, and inhome health, social, and supportive services. Services should be provided in such a way as to maintain and enhance personal independence in the community and in a setting preferred by the elderly and their families. Senator Baucus, thank you for inviting me to attend this meeting today.

Chairman BAUCUS. Thank you very much. I'd like to ask you, Patricia, about the New England Journal plan. You are the second one to suggest that. I heard someone else make the same proposal about a week ago. What basically is it and how do you think we should tailor it to Montana? And also in describing it, I would like the other panelists to think, from their perspectives, their point of view, how it would be tailored to the State.

Dr. HENNESSY. It's a 5-page article. I can try to summarize it for you. I am sure you have people on your staff that could summarize it better. Essentially it uses a principal health economy called monopsis, which is a single source payment. Right now if we look at how people pay for health care, they are multiple payers. If you assume that everyone would like to be a recipient, we know we've excluded certain people.

We've heard people talking about queuing and the Canadian people. There's queuing by 37 million people in this country and it's based on your income, not what position you are in the line. Using a single, central, publicly funded source that would be disbursed with State control, very much like the Canadian program, which has a provincial program or health ministries, and then the State essentially has a payment board which—I'm trying to think how—the payment board decides, then, issues that were raised before; how to set physician fees, and physicians, by peer pressure or peer review, monitor rates of payment.

I think that the next issue we would address is how do hospitals operate? They would provide, on a grow balance budget, and this is simplistic and I'm certainly not a health economist, I'm a physician that's kind of frustrated, I would say that a hospital, for example, would submit a budget that was similar to its previous year's budget and does not depend on the kind of medical free-for-all marketplace activities that may better work when you are making cars than when you are trying to provide health services. Right now we know we have hospitals that are underfunded, but have beds, and we also know there are people who would like services, but are excluded from the system. And so funding hospitals diminishes this kind of scrambling that gets them out of the business of providing patient care and gets them into a business arena where some believe they shouldn't be.

As I think through how to simply describe how the Canadian system would work here, I think the most important concept would be that it would be comprehensive and universal, that all the people would have access to these services. One would get a card which entitled you to receive services at a Montana hospital if you were a Montana citizen, and that would be enough to plug into it. Right now anyone who has tried to receive services realizes that there's a maze of people designed to see where you belong, and in some ways there's a parent to an unsophisticated person and you might believe you are being excluded from existing services and that's because before we treat you, we have to know who you're a beneficiary of. And in a Canadian-type system the assumption would be if you were a Montanan, you could get services from a Montana physician at a Montana hospital for medically necessary services, and there would be a State-controlled board that would

determine rates for reimbursement for physicians and for hospitals for the future.

Chairman BAUCUS. OK. You are a physician. What do you think? How can this be tailored or adapted so that Montana physicians think this is a good idea?

Dr. HENNESSY. When I've talked to my medical peers, and by and large I understand that many people are—I believe, just having worked for 2 years in a program that Don alluded to called Access Links, in which low-income women without medical benefits were channeled into the 16 or 20 physician offices in Missoula who provided obstetric care, we had a visitor, a CDC [Center for Disease Control] epidemiologist who came and heard about the program, asked for some details and said: My goodness, how is it that you are able to get Montana physicians without any financial incentive to take people without medical coverage into their offices? And he was quite surprised. I think the medical community, at least in Missoula, with which I'm most familiar, and in western Montana, is very socially concerned and doing the very best it can, but is overwhelmed, and one of the reasons——

Chairman BAUCUS. Overwhelmed with——

Dr. HENNESSY. The paperwork, with the regulatory intrusion. And many of those physicians have an accounts receivable—how can I say it? If you take a Medicaid patient and that Medicaid patient—perhaps there's a Social Security beneficiary status in question or perhaps that person also has Medicare or may have some resources that haven't been tapped into. There's no clarity about who, in fact, will pay for that person. If a doctor operates or treats this patient in their office, the billing is hung up for—it's not uncommon for it to be 6 to 18 months, as outlandish as this sounds. So a physician's actual income versus what's in the accounts receivable staggers because they are taking patients who have third-party payers. Right now Medicaid or Medicare makes it a disincentive for them to see more than what they believe are their fair share.

Chairman BAUCUS. The question, though, would Montana physicians like this program?

Dr. HENNESSY. I think they would. I think when we talk to our Canadian friends and we discover they have one billing clerk or a receptionist does the billing instead of six people in the back room, one with Blue Cross, one with Medicaid, I think Montana physicians will be astounded. I think the turnover—when it's explained to the Montana physicians that they have a less than 30-day turnover when they submit a bill and they submit a single bill, they will be flabbergasted.

Chairman BAUCUS. What are the incomes of Canadian physicians versus Montana physicians?

Dr. HENNESSY. I'm not a medical economist, and Canadian dollars are different from American dollars——

Chairman BAUCUS. As best you can.

Dr. HENNESSY. I think the best way for me to describe Canadian physician income and Montana physician income is—my husband asked me this question last night—I think in the United States we have a bell-shaped curve for the physician income distribution. We have all these low paid family docs on one end and these specialists

on the other end. The curve operates like this and we go here and all the way here. I don't get near as much as a neurosurgeon does. In Canada it's shifted like this. The very lowest paid Canadian physician is much closer to the very highest paid Canadian physician. And by and large from a standpoint of dealing with pluralities as we deal with in this country, when most of the people are happy, that's oftentimes the best we can do. I think it would make most of Montana physicians happy.

Chairman BAUCUS. What about other providers, hospitals, and nursing homes and Horizon Lodge——

Dr. HENNESSY. I can't speak for all of us. I would like to speak a little bit to hospitals. I think that hospitals—and the gentleman who spoke for the Montana Hospital Association could explain this much more eloquently than I can, he's been in the hospital business, which has been a caring business for a long time. And we have a history of treating everyone who comes along. As health care costs change in the marketplace—I have, as a physician, felt uncomfortable; it's taken me awhile to call it the medical marketplace. I didn't get into medicine to get into business. I thought I was going to be in service. As hospitals look at a competitive environment and begin to talk about their business as if they were making shoes or making cars, their focus has shifted. What they want to do, and that is serve everybody, and what they have to do in order to stay open, there's a disparity between the two. I think that Montana hospitals would like to get those two things closer, what they want to do and what they really do, and have them much closer together than what currently exists.

Chairman BAUCUS. Are there nursing homes in Canada?

Dr. HENNESSY. There are nursing homes in Canada, and I understand that the Canadians have not solved the long-term health care problems nationwide.

Chairman BAUCUS. Is that right, Steve?

Mr. STANLEY. That's right.

Chairman BAUCUS. Any reaction to what Patricia's outlined?

Dr. ESPELIN. I'll speak as a physician. There's a couple of issues here that are going to be difficult to resolve. Are the physicians going to relinquish that income for convenience? And that has to be settled. There's another question that needs to be answered. Who is going to direct what patients to what doctor and how is that going to be managed? It's important for a physician to have free choice of patients. There are some patients a physician just can't take care of. I have to tell you that it's very few patients, but on the other side of that coin it's also true, patients have to have freedom of choice of physicians because there are many physicians that some patients won't see.

Chairman BAUCUS. How does Canada take care of that?

Dr. ESPELIN. I have no idea, I have no information for you on that.

Chairman BAUCUS. Steve, I'm curious how, in your experience, the program outlined in the New England Journal of Medicine makes sense or does not make sense?

Mr. STANLEY. I did not understand it that well, to be very honest.

Chairman BAUCUS. Essentially, as I understand it, is the major payer to the State board who then decides who gets paid what?

Mr. STANLEY. That would help our program, if you had one payee.

Dr. HENNESSY. In the Canadian health ministries, I think there is a difference between Ontario and British Columbia, and that a State payment board would include all people who were to be considered.

Chairman BAUCUS. Steve, why aren't there more outfits like yours? That sounds reasonable.

Mr. STANLEY. I'm not sure. I think it's a new concept. I think at some time in the past the nursing home groups have been opposed to it, it was taking business away from them. I think with the elderly aging like they are, the influx we are having, there's a need for——

Ms. HUGHES. I would disagree with that. I think there is personal care that is very close to his assisted living program. Many long-term care facilities, nursing homes, also offer other kinds of arrangements for those that require lesser care——

Chairman BAUCUS. Doesn't it make sense for there to be kind of a merger between the two, have some system that's between nursing homes in one hand and the providers like Steve's in the other? It seems like an artificial continuation in some cases. I'm certain the services are needed, but——

Ms. HUGHES. I think our concept of who the residents are in our nursing homes is based on who was there 10 years ago. When I walk into nursing homes today, I don't see people who would be able to get along—or very small numbers of people who would be able to get along in the assisted living arena. Those people are being taken care of in personal care, in home health, in the Medicaid Waiver. We really have moved most of the people out of nursing homes who don't need to be there, and I think for the most part what we're left with in our facilities are people who are more and more acutely ill. Our nursing homes are looking more like hospitals.

Chairman BAUCUS. One final question and then we'll open it up to anyone else in the audience, and that is, do you know, Patricia, how the Canadian system is financed?

Dr. HENNESSY. I can read to you. Would you like me to read to you from the New England article?

Chairman BAUCUS. It depends how long it is.

Dr. HENNESSY. I think essentially the Canadian system takes health care dollars that come from both the Federal Government as well as the Provinces——

Chairman BAUCUS. Is that income taxes?

Dr. HENNESSY. And income tax, and I have an interesting article that describes how that income tax works, and that is the Canadian Provinces—it's not called that, it's called a premium, but it is essentially a tax.

Chairman BAUCUS. We have other words, too.

Dr. HENNESSY. Do you think they learn from us or we learn from them? And the premium is related to family size, but not risk status, and it covers only a portion of the total plan outlays, and they are compulsory for most of the population. However, your medical coverage is not conditional on your payment. Much the

way income taxes work. If you don't pay income tax, you still benefit from roads and other things that our society offers.

Chairman BAUCUS. Yes?

Mr. ESKRIDGE. It's actually a recapitulation, but one of the things that I've heard here, and it seems to me it's a very simple way of helping to control the cost, is to see that we go through the medical system the way the medical system was designed to go through. And if we constantly bypass the primary practitioner, which we, as Americans, seem to do today by one way or another, and some cases it's necessary; if you don't have the money to pay a primary practitioner, you go directly to the hospital, to the tertiary systems, but if we could get the system back to where we had family doctors and we had comprehensive care at that level and people that we could trust that weren't going in and out all the time and if we could start at that level, those people would know our problems more than just our health problems, but in most cases small communities, they also know more about us, then those people could refer us to the secondary facilities or tertiary facilities or to the specialists. I think there's a place for every one of those in the medical system, but we seem to bypass part of it.

Chairman BAUCUS. I want to thank you all very, very much. Thank you for your testimony. We've got some time for others that want to say something. It's 5:20 p.m., we can continue for, I'd say, at the most, 25 minutes, no more.

MEMBER OF AUDIENCE. I heard you say a lot of times about the private sector having to pick up a lot of this. I'd be willing to pay more income tax if the Federal Government would throw in their share of it, not like this thing we've got now with people paying more in court tax and stuff. I'm Ken Ricko [phonetic] from Darby and I would be willing to pay a little more income tax if the Federal Government would come in with their fair share, not like the 20-percent surtax we are paying now for this old-age thing we've got coming——

Chairman BAUCUS. You mean health care catastrophic——

MEMBER OF AUDIENCE. Yeah. That's all I have to say.

Chairman BAUCUS. I hear you. But basically you are saying that you are perhaps willing to pay your fair share as long as others are paying their fair share. We are paying our money into the Federal Government and this way we get back some of it that we paid in, which we haven't got yet. Any other comments?

MEMBER OF AUDIENCE. This is sort of new to me to be here today because I'm just a farmer, but I would like to say this to you and to your staff and to whoever operates this, do you get to talk to young couples from 30 to 60 to 80? I'm thinking more in terms of our younger people, they have more degrees than we do today, but I think they should be aware of this so that they can go and vote and have more on the ball than they have when they get to the poles, because I know where I've missed out a lot in my life and I'd like to see them be more educated to what the problems are.

Chairman BAUCUS. Health care problems?

MEMBER OF AUDIENCE. Health care problems for their parents and themselves. And thank you, I've really enjoyed this.

Chairman BAUCUS. Yes, sir.

MEMBER OF AUDIENCE. Senator, thank you again. Has the committee considered any part of a national health insurance plan in their discussion? It may be that if we could eliminate the paperwork and catastrophic health care, we may get a better endorsement from the medical profession.

Chairman BAUCUS. It's clear that some form of more universal and perhaps some form of mandated contribution will not only be considered, but seriously considered by the Commission. There are many, many ideas and most of them revolve around a lot of the points and comments that have been raised this afternoon.

MEMBER OF AUDIENCE. The Federal Government has proven they can do a good job administering insurance; the Veterans' life insurance, they have done an excellent job. Why don't they take a stab at national health insurance? We can—also, I'd like to shake hands with the man from Blue Cross-Blue Shield because they only raised the rate up 61 percent this January. Maybe if we could attack it from that angle we might get everybody to line up on reasonable health costs. It's catastrophic in every area. Thank you for your consideration.

Chairman BAUCUS. Yes?

MEMBER OF AUDIENCE. We were wondering, earlier we weren't hearing anything about the Alzheimer's disease. There are three of us here this afternoon from Hamilton and we are caregivers and we have Alzheimer's support groups there and we have quite a few caregivers, there's over 30 of us all together, and we're really concerned about this long-term health care, because you addressed it yourself one time and some of the ladies here were addressing it. We were concerned that maybe Alzheimer's wasn't being considered, because as you know now, there isn't such a thing as insurance for Alzheimer's, nothing to back us up at all, the people, the respite part of it, and that sort of thing. Now, my question will be, is there any way that this could be joined to or if there's going to be any amendments or anything like that done to the catastrophic bill that was passed last year? Could that be worked into there or would it have to be a different thing?

Chairman BAUCUS. I think that generally Alzheimer's care would be included in the more universal long-term care plan. That is it would include home health care, respite care, and other problems associated with Alzheimer's.

MEMBER OF AUDIENCE. But not be connected into the catastrophic——

Chairman BAUCUS. No. The catastrophic health insurance bill that passed deals primarily with acute care, with catastrophe, a short time basis of acute care rather than long-term health care, chronic care, which would be more associated with Alzheimer's.

MEMBER OF AUDIENCE. If any of you—I don't know if any of you here are familiar with Alzheimer's disease. If you are a caregiver or whatever, it can get pretty acute.

Chairman BAUCUS. Thank you.

MEMBER OF AUDIENCE. I'm Dr. Peggy Slesinger [phonetic] from Missoula. I'm the pediatric rheumatologist in Montana. I'm the only pediatric rheumatologist from Seattle to Minneapolis. There's now one in Denver and the one in Utah just moved to Hamilton, so I take care of folks in a large State with a large referral base. I've

been the beneficiary of maternal health care funding and that just ended in June and we were lucky enough to have continued funding, but rural health care is not a problem of just the elderly, but there are many problems with children with diseases. I don't know if that's been brought up. A national health plan, I would be thrilled to death to participate. I think as a specialist it would improve access to care and it would also improve what specialists are available and what care is available by educating a network of primary caregivers.

Chairman BAUCUS. I appreciate that. You are a pediatrician or kind of a pediatrician?

MEMBER OF AUDIENCE. I'm an internist.

Chairman BAUCUS. Pediatricians are very passionate people——

MEMBER OF AUDIENCE. Absolutely.

Chairman BAUCUS [continuing]. What about some of the other docs, the knife and scope guys, are they also as willing to participate in the kind of plan you just mentioned?

MEMBER OF AUDIENCE. Well, my two comments about that, I have clinics in Montana, Billings, Great Falls, Helena, and Missoula. I'm familiar with many of the physicians in each of those areas. I have a regional practice as opposed to a city-focused practice, and I know of physicians in every one of those communities who would be pleased as punch to participate. And some of them are pediatricians, but not all of them. I also spent 4 years practicing in Great Falls and I know that the feeling of the Great Falls physicians is much different than the feeling in the Missoula community toward any sort of nationalized——

Chairman BAUCUS. Why?

MEMBER OF AUDIENCE. Well, they vote Republican, what can I say? I think on the one hand the compassionate side of taking care of folks on a national health plan is not absent from the Great Falls contingent. There are many people who took care of everyone who was indigent prior to any sort of reimbursement on the Medicare system and were happy to do it. When Medicare came in, the physicians would say, I did this for free and now I'm supposed to take 40 cents on the dollar? It's a more demeaning event to take less than what you are worth than to donate your services.

Chairman BAUCUS. I'm meeting this evening with the Missoula physicians, what points should I make?

MEMBER OF AUDIENCE. I think that the access to care is a major issue, it certainly is in the patients that I take care of, and I think access to care would be improved dramatically by a health care approach. What Pat alluded to, when you present things to physicians in this community as if it would be of benefit to everyone on the whole, the feeling is mutual and all of us are working together and doing good. If you present it to physicians, as you might to any group of folks, and say, this is how the Government wants you to do it, then there's a feeling here, as there is anywhere, we say, we don't want any part of that.

At the moment everyone seems so fed up with the regulations, billing, with the hassle of the business side of these things that the caregiving has been lost. And that feeling of wanting to be more of a caregiver, I think it's diluted by all of those—it's just like static in a practice, and I think removal of that would be a great benefit.

There are problems with the Canadian system, everyone knows that. There are the Canadians that come to the border for care. That is, I think, something we can deal with on a different scope in the States and I think something uniquely in Montana we could take care of.

Chairman BAUCUS. As you understand it, what's the standard problem in the Canadian system?

MEMBER OF AUDIENCE. I think there is a difference of allocation of services, it's different than this country. As I understand it, it's more of a seniority system of subspecialists. In other words, if you were a cardiac surgeon age 30 straight out of training and you decided to live in Vancouver and there were two age-60 surgeons there with more training, you wouldn't be able to practice your specialty in that locality. In this country we're not used to that practicing where and what.

Chairman BAUCUS. Who else?

MEMBER OF AUDIENCE. I'd like to comment on a couple of things, sir. When a caregiver is needed for a child, a handicapped person, or an elderly person, the objective is the same. It should probably be a service program. I hear that many disabled grandparents needing assistance really make a good voluntary person themselves with proper direction. There's no reason why we are fragmented and segmented into the elderly, the handicapped, and the children.

The other point I would like to make is apparently what is needed is a service program to educate the general public about health care, training for service practitioners, and perhaps even paid respite care providers for our volunteer caregivers as a part-time community consolidated employment program, including the training. I want to thank you for having this opportunity to say these few words.

MEMBER OF AUDIENCE. There's been a lot of talk about the cost of paperwork. I want to put in one thing. In Canada the cost for payment and the paperwork is $21 per person, per Canadian. Which in the United States both public and private handlers of the health care runs $95 per person, almost six times as much for the cost of the paperwork here as compared to Canada.

Chairman BAUCUS. It's high. I've spent time in Montana hospitals, at doctors' offices and am astounded at all the paperwork.

MEMBER OF AUDIENCE. I am Al Warren from Alda, MT, and I've been retired for 10 years and I belong to several retirement organizations like Montana Senior Citizens Association, AARP, and I think you are on the right track when you are talking about a national health plan, because all those organizations, as I see it, are in favor of this plan, so good work to you, keep it up.

Chairman BAUCUS. Thank you.

MEMBER OF AUDIENCE. Senator Baucus, I'm Kathy Ward, I'm the wife of John Ward, the college professor that you referred to who had an aneurysm about 2 years ago. The paperwork that's been referenced to, I would like to comment that as a family member who tried to keep very close track of exactly where we were once John had had his surgery and we were transferred from Missoula St. Pat's to Missoula Community, I found out, with no communication whatsoever, after the fact, not before, no consultation from anyone from either hospital, that the cost at Missoula Community

Hospital would be $20,000 per month. "And you, Mrs. Ward, have to pay $20,000 per month." And I said: "Well, then, what is plan B? Because we certainly don't have the kind of resources that we can stay here very long. Looks to me like we have 1 month."

I worked very hard. John then had a setback, he was put on a medical floor. I kept very close watch over the finances and what was being spent, what wasn't. In the end, after speaking with the Blue Cross-Blue Shield people and being assured there was coverage here, being assured that from Missoula Community there was coverage there, we now are still in a debate over $25,000. So the paperwork also has a huge effect on the family even if you do have insurance, and so I just wanted to comment, and I also wanted to ask Dr. Hennessy, if she's still here, doesn't look like she is, where would the insurance companies—what would be their view of national health insurance and what are we going to have to do to work with those people? Because it seems to me that that was never mentioned today and that certainly would be a big issue. Thank you.

Chairman BAUCUS. Thank you very, very much. Who else?

MEMBER OF AUDIENCE. Senator Baucus, my name is Tim Cano [phonetic]. I've worked in the insurance industry for several years now, I sell insurance is what I do, and the problems I see in dealing with people, and I deal with people, families, and there's a budget, there's a tight budget there, and to be able to afford medical insurance and then we look across and now they are talking to the elderly about medical supplement insurance if you end up in the nursing home, and if you bought insurance for every single thing that could happen to you, you would have nothing left to eat and have a roof over your head. I see a tremendous problem there. I've seen the rise in medical insurance, the rise in premiums too, 300 percent just in the few years I've been involved. I've seen the cost of care rise.

To address your issue, insurance companies, some are bothered and some aren't, but by the most part the insurance industry is against it, I would say. Not personally, but for the most part they're against it. The problem I see more than the cost of medical care, what are we going to do about long-term costs and the lack of education on the part of the American people as to what causes you to have medical problems? The doctor here from Helena, great point: Smoking, overweight, poor nutrition, those kinds of things have to be addressed, I feel.

The issue that you raised earlier about those people, the yuppy generation, spending as fast as we get it, those things are prevalent in our society, those have to be addressed, as well.

That's what insurance is all about. You earn your wages, you insure against losses. Everybody buys auto insurance, people buy homeowner insurance because they might lose due to their home burning down, car loss. Same thing with medical costs, you save money for retirement and a catastrophe happens. Those are the things that, as individuals, we have to address. I meet many people who choose to say, I don't want to address those issues. That's their choice and that's what our country is built on, I guess. Maybe, and maybe we need national health care, but it could become a tremendous problem because of the—but basically it could be the same

problem we are having with Medicare now, not enough being paid out, people have problems with claims and these kinds of things, and I guess your committee will address those issues. But I want to stress the education, and people have to take on personal physical responsibility.

Chairman BAUCUS. Thank you, Tim, very much. Who else?

MEMBER OF AUDIENCE. Senator Baucus, my name is Richard Hart. One thing that was never addressed is the problem of funding for people on a fixed income. I know a person that gets Social Security. For her to go into the hospital I think it's $3, or something like that, on Medicare/Medicaid Part A and B, or something like that. A clinic visit is $1 per visit. I could be wrong on these figures. But for them to bear all this cost is quite—well, for 30 days that's $90 for a hospital visit. And for a person that's on Social Security it's about—well, I know one person is earning about $324 on Social Security. Roughly that's about one-fourth of their Social Security for health care. One possible solution is to take money from foreign aid, from unneeded defense spending, and allocate it for adequate health care, for domestic health care, and for rural and domestic services as needed.

By the way, I should introduce myself, I'm Richard Hart, I'm a private citizen. And a second problem that's needed is these people that are on fixed incomes that get Social Security and supplemental securities, they shouldn't have to be deprived of these incomes for medical expenses when they've got other expenses such as property taxes, bills, power bills, heating bills, sewer, garbage, and, above all, their food bills and bills for clothing and things like this. If the Government can afford to send foreign aid, such as aid to the contras and aid abroad and spend a lot for unnecessary defense spending, well, they should be able to help the people who really need it here in Missoula and western Montana and throughout the country. And I'd also like to say my name is Richard Hart. I'm a little nervous.

Chairman BAUCUS. Thank you, Richard, very much.

MEMBER OF AUDIENCE. What I wanted to do is not to tell you anything particularly important, but I had occasion to visit the physician about 2 months ago and I says to him, I says, doc, I can't remember a thing anymore. And he looked me over and he gave me a prescription. He says, forget it. Thank you.

Chairman BAUCUS. I'll tell you one thing, we are not going to forget the testimony today. This has been very, very helpful, it's very constructive, and frankly, today's testimony has gone beyond my expectations.

There are many thanks I want to give today. First, to Dorothy. She was here awhile ago. She helped organize and brought a lot of witnesses, took care of their arrangements so they could come here today. Let's give Dorothy a round of applause. Also, thanks again to Fran, Fran Henderson, who has dutifully been transcribing, making a record of all the pearls of wisdom this afternoon. I want to thank, as well, the chairman of the Commission, Jay Rockefeller. He has agreed to have the hearing here in our State. We thank Senator Rockefeller for that. Thanks to all the witnesses who came, I appreciate your help, and thanks to everybody.

[Whereupon, at 6:40 p.m., the hearing was adjourned.]

APPENDIX

STUDY ON

HIGH COST MEDICAID INFANTS

JANUARY, 1989

MONTANA DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
PO BOX 4210
HELENA, MT 59604

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STUDY
ON
HIGH COST MEDICAID INFANTS

PRESENTED
TO

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DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

BY
PRENATAL CARE COMMITTEE

JANUARY, 1989

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I. SUMMARY:

The Omnibus Reconciliation Acts of 1985, 1986 and 1987 allowed states a number of options in extending Medicaid benefits to pregnant women and to children. In an effort to determine which, if any, of the options would be appropriate for Montana to select, the Economic Assistance Division of the Department of Social and Rehabilitation Services established a study committee in May of 1988.

The committee focused on high cost infants born in 1986 and their mothers. ("High cost" was defined as over $10,000 in Medicaid expenditures during the first year of life.) Through a computer search, 83 infants were categorized as high cost. Only eighty-one (81) mothers were included in the study since five of the high-cost infants were twins.

These 83 babies represented only 2.7% of the 3031 infants covered by Medicaid during 1986. However, the Medicaid costs associated with this group of 83 infants totaled $2,696,461 or 50.6% of the entire expenditures for Medicaid infants during that calendar year.

$3,539 - less than 2.7 million

The committee attempted to: $\frac{2696461}{83} = \$32487.48$ @

1. Determine whether the high costs of these infants were associated with premature birth and low birth weight; and

2. Identify the barriers that the mothers of these infants may have faced in accessing prenatal care.

Over half (55.4%) the infants in the study were low birth weight. Compared to all the women who gave birth in Montana during 1986, the study group of mothers was characterized by their youth, their high incidence of out-of-wedlock births, and their lack of a basic (high school) education. Whereas the vast majority of mothers in the study group were Caucasian (80.0%), it is important to note that Indian women are over-represented in the sample.

These findings are consistent with national studies which have identified certain factors which, if present, increase a woman's risk of delivering a low birth weight infant. The demographic risk factors include:

1. Age

2. Race

3. Low Socioeconomic Status

4. Unmarried

5. Low Level of Education

Although the majority of mothers in the study group fit the demographic high risk profile for delivering a low birth weight infant and many of the mothers had severe medical problems, most (66.2%) of the mothers in the study group received inadequate prenatal care.

The vast majority of these women were eligible for Medicaid with no incurment (79.7%). However, nearly two-thirds of these women (62.9%) did not apply for Medicaid benefits until shortly before or immediately following the birth of the child.

II. INTRODUCTION:

During the past two years, many states and federal agencies have focused on a critical problem facing our nation -- namely, the high rates of infant mortality among low-income populations. During this same time period, Montana has been experiencing a crisis in obstetrical/gynecological health care delivery. This crisis has been due, in large measure, to the rapidly escalating costs of liability insurance. In 1986, 213 physicians in Montana offered these services. In 1987, the number dropped to 193 physicians and it is believed that 1988 saw a further decline in services to include only 152 physicians statewide. This decline represents a 29% reduction of obstetrical/gynecological (OB/GYN) services.

In addition, not all physicians who offer OB/GYN services extend these services to Medicaid recipients. This is largely due to the significant difference (60%) between customary charges for OB/GYN services in Montana and Medicaid payments.

In May of 1988, an Economics Assistance Divisional committee was established to review Medicaid options for pregnant women, to determine the feasibility of adopting such options in Montana, and to make recommendations to the Department administrators prior to the 1989 legislative session.

Members of the committee are:

Dee Capp, Administrative Officer III, Primary Care Section, Medicaid Services Bureau

Judy Garrity, Management Analyst III, Policy and Training Section, Field and Program Management Bureau

Pat Huber, Administrative Officer III, Medicaid Therapies and Pharmacies Section, Medicaid Services Bureau

Penny Robbe, Supervisor, Policy and Training Section, Field and Program Management Bureau

Medicaid options include the following:

A. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN:

The Omnibus Reconciliation Act of 1986 (OBRA 86) allows states to provide an optional period of presumptive eligibility to pregnant women in order for them to receive prompt prenatal services.

If a qualified Medicaid provider determines that the pregnant woman's family income does not exceed a specific standard, that provider certifies that the pregnant woman is presumptively eligible. The pregnant woman can then receive prenatal services for a period of 14 to 45 days. If the woman does not file an application for Medicaid with the county office within 14 days, the

presumed eligibility continues until the county makes a final determination or 45 days, whichever is earlier.

States have the option of requiring the qualified Medicaid provider to determine resource eligibility or any other eligibility factors if they so desire.

Qualified Medicaid providers may be chosen by the states as long as they meet various federal criteria. Some examples could be county health departments or WIC programs.

B. COVERAGE OF POOR PREGNANT WOMEN AND INFANTS TO AGE ONE YEAR AT 185% OF POVERTY):

With the enactment of OBRA 1987, states are allowed to provide coverage for pregnant women and infants to age one year if the family's income does not exceed 185% of the official poverty level for that family size. A resource test is optional for this group. (185% of poverty for a family of three is currently $17,926.50.)

In this program, the states cannot choose to separate coverage for pregnant women and infants. If coverage is extended for one group, it must be extended for the other group as well.

C. EXTENDED COVERAGE TO POVERTY PREGNANT WOMEN AND INFANTS UP TO AGE ONE:

The Catastrophic Coverage Act of 1988 mandates states to extend Medicaid benefits to pregnant women and infants up to age one with incomes at or below 100% of the federal poverty level. Coverage will be phased in beginning July 1, 1989, with those women and infants whose income is at or below 75% of the poverty level. Effective July 1, 1990, women and infants with income within 100% of the poverty level will be potentially eligible for Medicaid benefits. A resource test is optional.

D. EXPANDING THE PROVIDER BASE FOR PRIMARY HEALTH CARE SERVICES:

The Medicaid Bureau is reviewing options which may expand the provider base of primary health care services, such as prenatal services. Some possibilities which are being reviewed are: public health departments with physician directors providing physician services and billing Medicaid for such services; working with the nurse specialists to become Medicaid providers and bill for services; reviewing the feasibility of allowing a health care facility, such as a hospital, to provide outpatient physician services such as prenatal clinics; and evaluating the potential for family planning clinics to provide additional primary health care services.

The review by staff will include the providers' interest in participating with Medicaid to provide the services, reimbursement issues, and the scope of services allowed by federal regulations and state law for the various provider types.

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Crucial issues in providing prenatal and delivery services to the Medicaid clientele are the ability to attract qualified health care providers and the level of Medicaid reimbursement for the services.

E. CASE MANAGEMENT:

Under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), state Medicaid programs were given flexibility to implement targeted case management systems and to develop enhanced benefit packages for pregnant women.

The economic status of low-income women is one factor which increases their risk of giving birth to a low birth weight or otherwise unhealthy infant. A woman's health status, environmental conditions and psychosocial elements within the family structure must also be evaluated when determining her risk factors.

A case management option could be developed under Medicaid services. The case management system would assist the individual in obtaining the necessary health services as well as assessing her social, economic and environmental influences. While the physician would be primarily responsible for determining the medical needs and treatment plan, the case management broker would implement the plan and assist the client in obtaining the necessary services.

A case management system further insures that "presumptive" eligibles (if that option is selected) follow through with a formal Medicaid application.

As case management is considered an optional service, the Legislature must review and approve Medicaid's capability to implement such a service. Case management services applied to one group may also apply to the health care management of other catastrophic illnesses such as AIDS, long term chronically ill, brain stem injured individuals, or respirator-dependent individuals.

F. CONTINUOUS ELIGIBILITY:

OBRA '86 also allows states to implement programs that guarantee an eligible woman uninterrupted coverage throughout her pregnancy, regardless of fluctuations in her family income or resources. Periodic redetermination of eligibility could then be eliminated for this group.

III. METHODS, ORGANIZATION, AND LIMITS:

A. METHODS AND ORGANIZATION:

In order to determine which of the OBRA options (if any) would be appropriate for Montana to consider, more information was required. By assessing how pregnant women and infants are now faring in Montana, we could then decide what needs to be done to improve their access to and use of medical services.

We decided to look at Medicaid babies (born within a particular calendar year) and their mothers. 1986 was chosen as the study year, since Medicaid claims would be completed for that period of time. The Montana Income Maintenance System (MIMS) indicated that 3031 infants were covered by Medicaid within the calendar year of 1986. The Medicaid costs associated with this group of infants totaled $5,326,002.

Since the entire group of 3,031 infants would have been far too time consuming to study, it was decided to study only those infants whose Medicaid costs exceeded $10,000 during the first year of life. MIMS indicated that 83 infants fell into this category. The Medicaid costs associated with this group of 83 infants totaled $2,696,461 or 50.6% of the entire expenditures for Medicaid infants during that calendar year.

An in-depth study was conducted on the 83 infants to determine whether their high costs were associated with premature birth and low birth weight. The study also attempted to identify the barriers that the mothers of these infants may have faced in accessing prenatal care.

The infants were identified by MIMS with social security number, date of birth, case number, and the amount of Medicaid dollars spent on their care during the first year of life. Mothers of the infants were then identified through the case number or, in some cases, by contacting the county offices.

Medicaid claim histories for both the infants and their mothers (if mothers were covered by Medicaid) were pulled using the Surveillance and Utilization Review System (S/URS). These claim histories provided information regarding the birth weight of the child, any congenital anomalies, type of medical procedures used, etc. The claim histories also indicated subsequent hospitalizations during the first year of life. Mothers' claim histories indicated any hospitalizations which may have occurred prior to the birth of the child or other medical/psychological problems which were being treated.

County welfare offices of the study group were contacted and asked to fill out forms and return them to the state office. The form identified the mother by name and social security number and indicated a time period which spanned nine months prior to the birth

of the child as well as the month of the child's birth. Counties were asked to look at the case records for these women and indicate:

1. The date(s) they applied for Medicaid coverage during this time span;
2. The date(s) of approval or denial;
3. The reason for any denials;
4. The date(s) of eligibility within the allotted time period; and
5. The amount of incurment, if any.

Demographics of the mothers of these high cost infants were manually manipulated with information gathered from MIMS or through county contacts. The women were grouped by age, race, and county of residence.

A review of the birth certificates of these high cost infants was made by the Bureau of Vital Statistics of the Montana Department of Health and Environmental Science. Birth certificates for only 65 of the babies could be found. (Some of these high cost infants were born in medical centers out of state.) The Bureau of Vital Statistics then gathered information on these 65 infants and compared the information to the total number of infants born in Montana during 1986. Computer comparisons were run on:

1. Age of mother at birth of the child;
2. Race of mother;
3. Marital status of mother;
4. Educational level of mother;
5. The number of prenatal visits of mother; and
6. The month prenatal care began.

Some physicians or hospitals were contacted to determine the amount of prenatal care these women received during their pregnancies. Initial contacts were made for those infants whose Medicaid costs exceeded $40,000 during the first year of life and whose mothers were covered by Medicaid at the time of birth.

Questions to which the providers responded are as follows:

1. When did the client first come to your office for prenatal care:
2. What was the expected date of delivery?
3. Was this client referred to you by another physician?
   If so, what month of the pregnancy was the referral made?
   What was the reason for the referral?
4. Was this pregnancy classified as high risk?
   If so, for what reason?
5. Number of prenatal visits provided by your office?
6. What was the birth weight of the baby?

B. LIMITATIONS OF THE STUDY:

The study group (65 infants and their mothers) was compared to the total number of babies born within Montana in 1986 and their mothers. It was not possible to compare the study group to all babies born in 1986 who were covered by Medicaid (3031 infants). Such a comparison would have involved identifying all 3031 infants and their mothers by name which would have taken an enormous amount of time and effort by a limited number of staff persons working on the study. It would have also involved a great deal of time spent by county staff.

It was also not possible to compare the study group to the overall welfare population in Montana in 1986 as the particular data is not available.

The data obtained from the study group was then compared to data on the total number of infants (and their mothers) born within the state in 1986. (Total state births for 1986 were 12,765.)

IV. FINDINGS:

A. DEMOGRAPHICS:

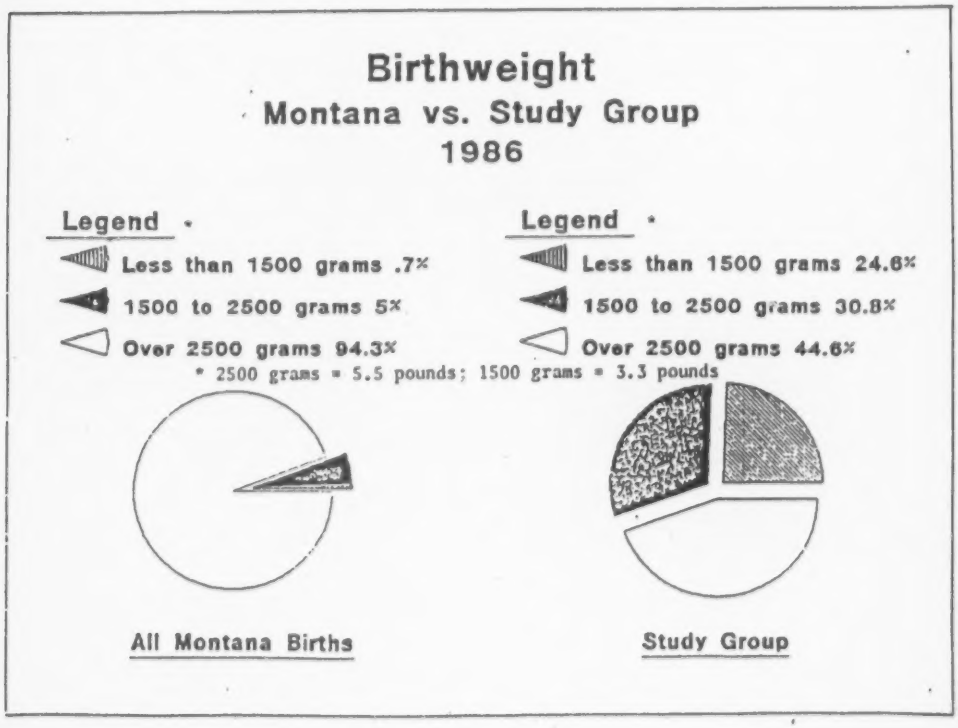
MONTANA GROUP

STUDY GROUP

BIRTH WEIGHT

During 1986, 5% of all babies born in Montana weighed between 1501 grams and 2500 grams. An additional .7% were very low birth weight or under 1500 grams. The total of low birth weight babies was 5.7%.

Within the study group, 30.8% of the babies weighed between 1501 grams and 2500 grams. An additional 24.6% were under 1500 grams. The total of low birth weight babies in the study group was 55.4%.



MONTANA GROUP

STUDY GROUP

AGE OF MOTHER

Of the 12,765 babies born in 1986, only 6 were born to women under the age of 15. (This did not calculate into a recordable percentage rate.) Ten percent (10%) of the state births were to women between the ages of 15 and 19. Another 30.2% of the births were to women between the ages of 20 and 24. Therefore, 40.2% of the women who gave birth in Montana in 1986 were under the age of 25.

Of the women in the study group, one mother or 1.5% was under the age of 15; 26.2% were between the ages of 15 and 19; and 46.2% were between the ages of 20 and 24. Total percentage of mothers in the study group under the age of 25 was 73.9% -- nearly twice the state average. Furthermore, the study group had a much higher incidence of teen births -- almost three times the state average.

Age of Mother
Montana vs. Study Group
1986

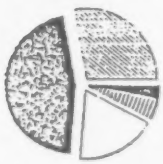
Legend

- Under 19 10%
- 20 to 24 30.2%
- 25 to 29 34%
- 30 to 34 19.7%
- Over 35 6.1%

All Montana Births

Legend

- Under 19 27.7%
- 20 to 24 46.2%
- 25 to 29 18.5%
- 30 to 34 4.6%
- Over 35 3.1%



Study Group

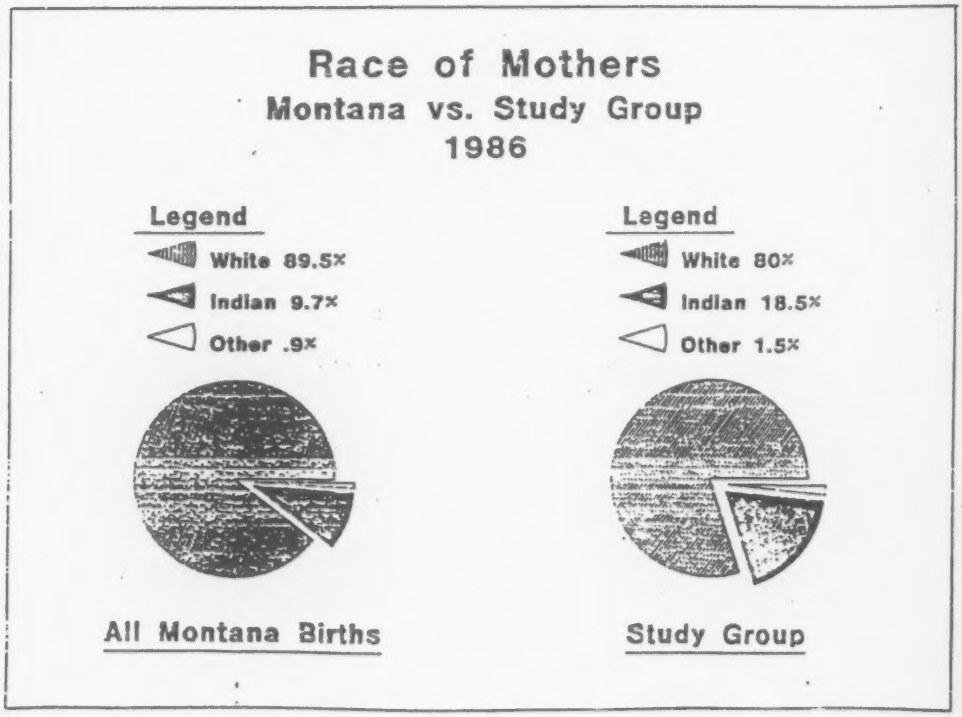
MONTANA GROUP

STUDY GROUP

RACE

Of the 1986 Montana births, 89.5% were to Caucasian women; 9.7% were to Indian women.

Within the study group, 80.0% of the births were to Caucasian women while 18.5% were to Indian women. (The number of Indian women represented in the sample is nearly twice as high as the state average.)



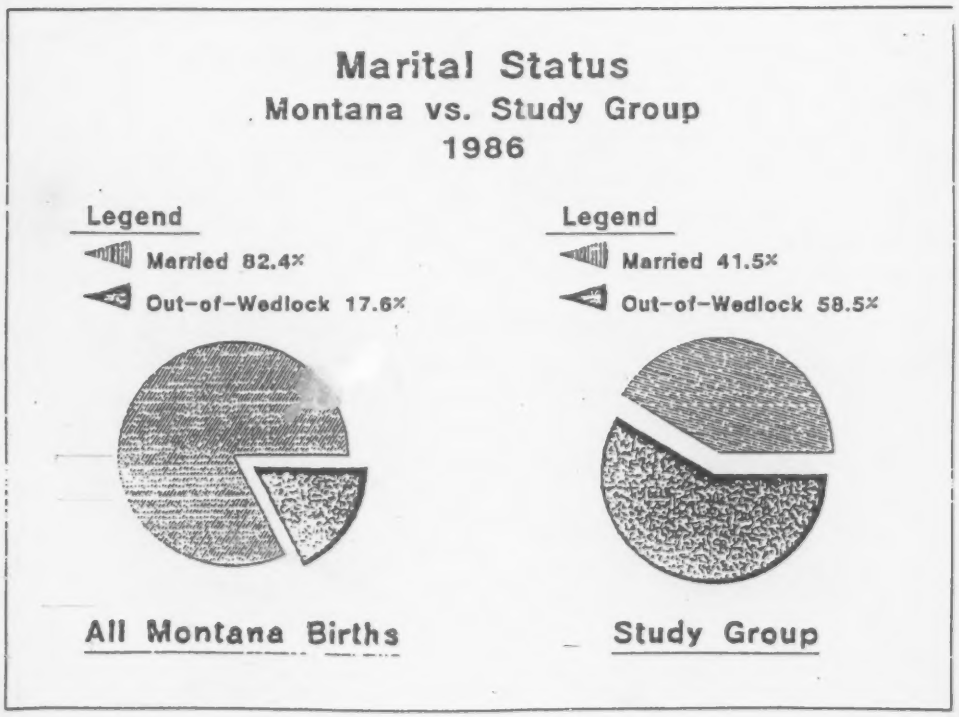
MONTANA GROUP

STUDY GROUP

MARITAL STATUS

Of the total number of Montana babies born in 1986, 17.6% were out-of-wedlock births.

Of the study 58.5% were out-of-wedlock births -- more than three times higher than the state average.



MONTANA GROUP

STUDY GROUP

EDUCATIONAL LEVEL

There were 12,765 women who gave birth in Montana during 1986. Within that group 282 (2.2%) had an eighth grade education or less.

Of the 65 women in the study group, 6 women (9.2%) had an eighth grade education or less.

1,606 women (12.6%) had between 9 and 11 years of education.

27 women (41.5%) had between 9 and 11 years of education.

5,348 women (41.9%) had completed high school.

22 women (33.8%) had completed high school.

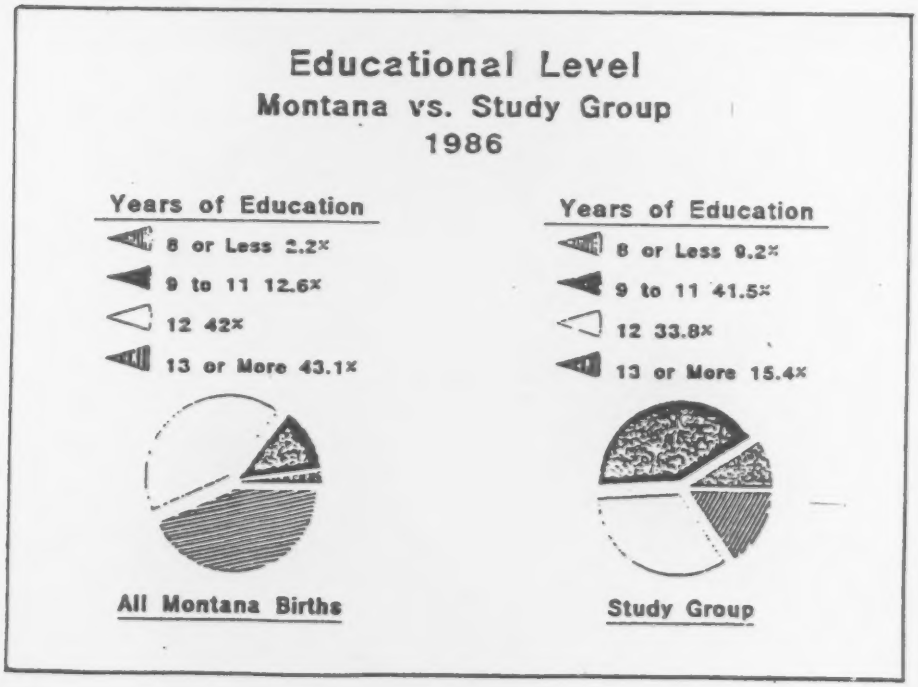
4,793 women (37.5%) women had at least some post-secondary education.

10 women (15.4%) had at least some post-secondary education.

694 women (5.4%) had completed college and had some post graduate work. (Data for 0.3% of the state group was unavailable.)

In the Montana group, 14.8% had less than a high school education.

In the study group, 50.7% had less than a high school education.



MONTANA GROUP

STUDY GROUP

PRENATAL CARE

According to a United States General Accounting Office report, prenatal care is insufficient if it does not begin within the first three months of pregnancy or if there are eight or fewer prenatal visits. According to the American College of Obstetricians and Gynecologists, prenatal care should begin as early in the pregnancy as possible with thirteen prenatal visits considered ideal. Women with medical complications are advised to see a health care provider more often.

77.0% of the state group reported initiating prenatal care during the first trimester of pregnancy.

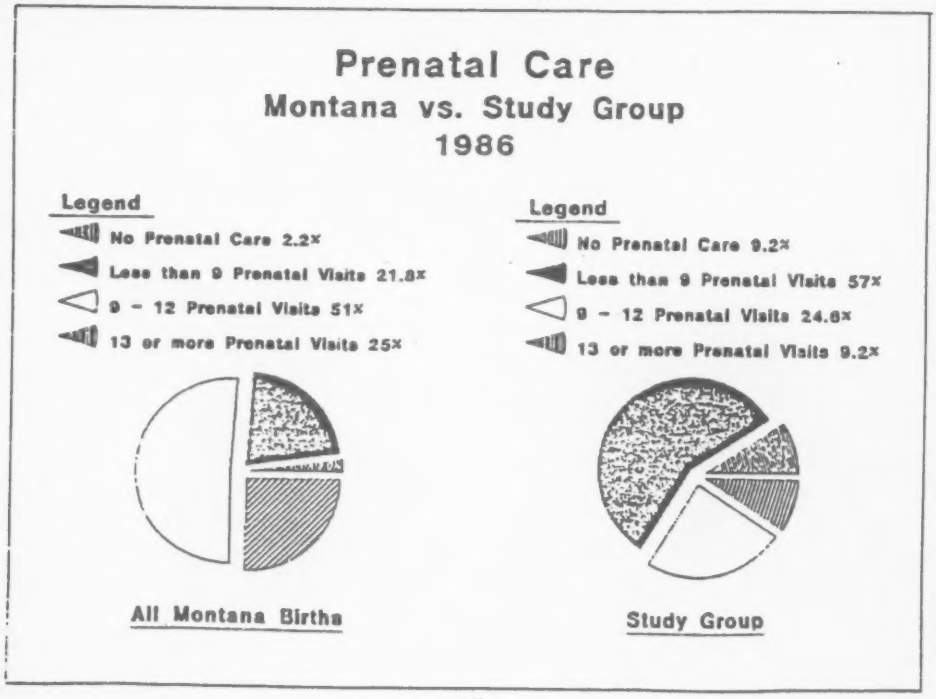
Of the state group, 21.8% reported less than 9 prenatal visits. An additional 2.2% reported no prenatal care or the data on prenatal care was unavailable.

50.9% reported 9-12 prenatal visits. 25.0% reported 13 or more prenatal visits.

55.0% of the study group reported initiating prenatal care during the first trimester of pregnancy.

Of the study group, 56.9% reported less than 9 prenatal visits. An additional 9.2% reported no prenatal care or the data on prenatal care was unavailable.

24.6% reported 9-12 prenatal visits. 9.2% reported 13 or more prenatal visits.



MONTANA GROUP

STUDY GROUP

PREVIOUS PREGNANCIES

Women under the age of 25 in the state group have the following obstetrical history:

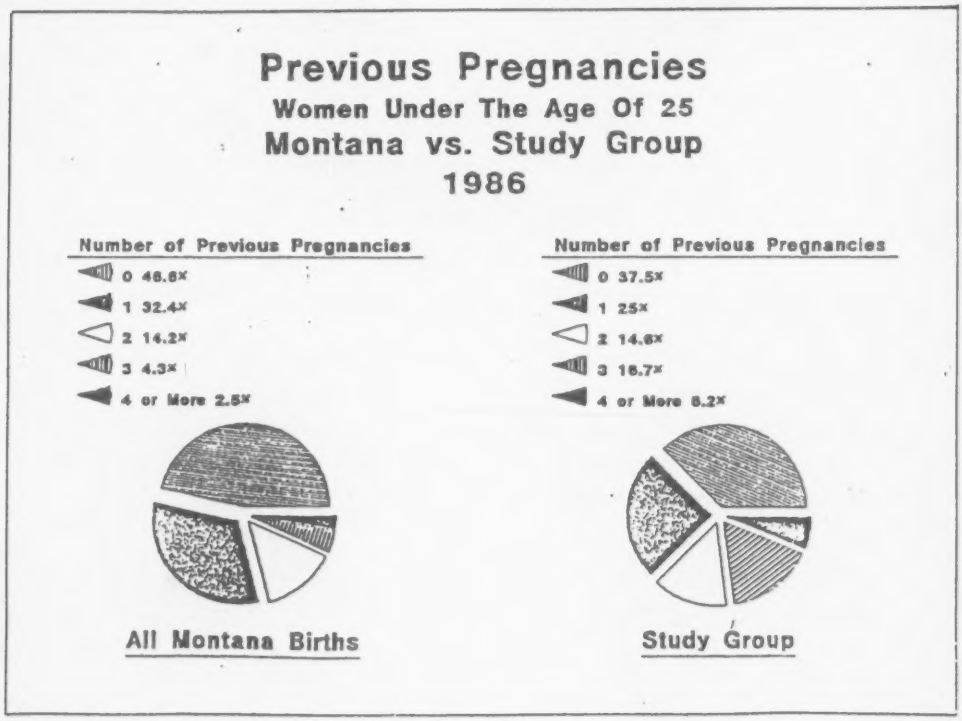
46.6% - 0 previous pregnancies
32.4% - 1 previous pregnancies
14.2% - 2 previous pregnancies
4.3% - 3 previous pregnancies
2.5% - 4 or more previous pregnancies

21% of the state group under age 25 had 2 or more previous pregnancies.

Women under the age of 25 in the study group have the following obstetrical history:

37.5% - 0 previous pregnancies
25.0% - 1 previous pregnancies
14.6% - 2 previous pregnancies
16.7% - 3 previous pregnancies
6.2% - 4 or more previous pregnancies

37.5% of the study group under the age 25 had 2 or more previous pregnancies.



MONTANA GROUP	STUDY GROUP

RACE BY AGE

On a statewide average in 1986, 21.8% of the Indian women who gave birth were teens (under the age of 20). Another 36.0% of the Indian women who gave birth were between the ages of 20 and 24. Therefore, 57.8% of Indian women who gave birth in Montana in 1986 were under the age of 25.	Within the study group, 33.3% of the Indian women were teens and another 58.3% of the Indian women were between the ages of 20 and 24. Therefore, 91.6% of the Indian women in the study group were under the age of 25.
11,421 Montana births in 1986 were to Caucasian women. Of this number, 8.7% were to teens. An additional 29.5% were to women between the ages of 20 and 24. (38.2% of the 1986 Caucasian mothers were under the age of 25.)	Of the Caucasian women within the study group, 25.0% were teens -- nearly three times higher than the state average. An additional 44.2% were between the ages of 20 and 24. (Total of 69.2% under the age of 25.)

WEDLOCK BY AGE

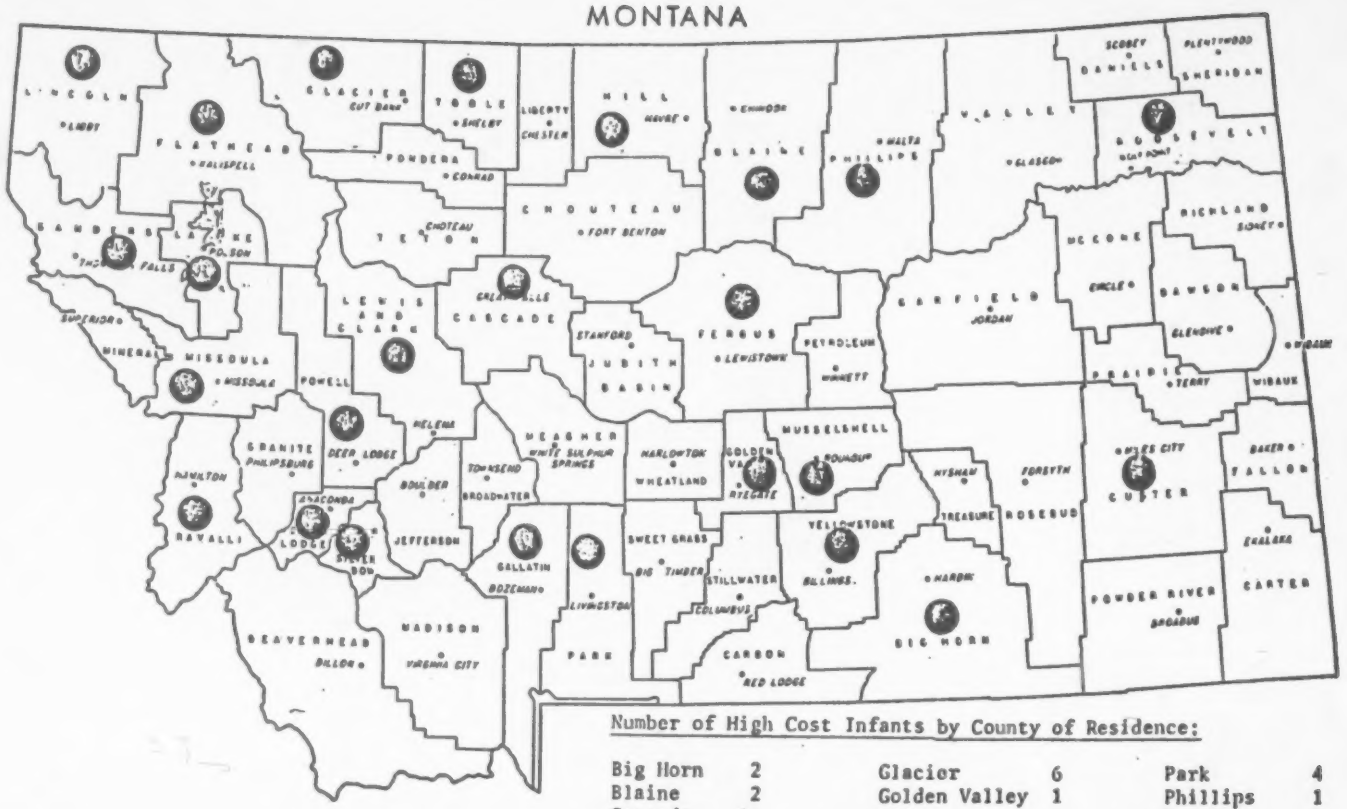
On a statewide basis, 58.1% of the teens who birthed in 1986 were unmarried. 21.9% of the women between the ages of 20 and 24 were unmarried.	Within the study group, 94.1% of the teens were unmarried. Forty percent (40%) of the women between the ages of 20 and 24 were unmarried.

WEDLOCK BY RACE

Of the Caucasian women who gave birth in 1986, 87.1% were married; 12.9% were unmarried.	Of the Caucasian women in the study group, 46.2% were married, 53.8% were unmarried.
Of the Indian women who gave birth in 1986, 38.2% were married; 61.8% were unmarried.	Of the Indian women in the study group, 25.0% were married, 75.0% were unmarried.

COUNTY OF RESIDENCE:

The map on page 16a shows the distribution of these 83 infants according to county of residence.



Number of High Cost Infants by County of Residence:

Big Horn	2	Glacier	6	Park	4
Blaine	2	Golden Valley	1	Phillips	1
Cascade	11	Hill	4	Powell	2
Custer	3	Lake	2	Ravalli	2
Deer Lodge	1	Lewis & Clark	7	Roosevelt	1
Fergus	1	Lincoln	1	Sanders	3
Flathead	4	Missoula	5	Silver Bow	4
Gallatin	2	Musselshell	1	Toole	2
				Yellowstone	11

B. OTHER FINDINGS:

After identifying and comparing the demographics of the two groups, it was necessary to determine:

1. At what point these women applied for Medicaid (prior to conception, during the pregnancy, or after the birth; and

2. Whether the women were eligible with an incurment.

Of the 81 mothers in the study group, the eligibility and incurment data was unavailable on 6 mothers (7.4%). Seventeen (17) mothers (21.0%) were covered by Medicaid 181 to 270 days prior to the birth of the child. Another 7 women (8.6%) were covered 91 to 180 days prior to the birth. Eighteen (18) mothers (22.2%) were covered 1-90 days prior the birth; 33 mothers did not apply until after the birth of the child (40.7%).

Sixteen (16) of the mothers were eligible for the Medically Needy Program with an incurment. The other 59 mothers had no incurment.

In order to estimate the number of pregnant women who applied for Medicaid coverage during a given fiscal year, a program was written and run on the MIMS system for state fiscal year 1988, ending June 30, 1988. The data indicated that 871 pregnant women applied for and received Medicaid coverage during that year. Ninety-one (91) pregnant women applied for Medicaid coverage but were denied. An additional 18 pregnant women were both eligible for and denied coverage during the same fiscal year. Approximately nine pregnant women in ten who apply for pregnancy-related medical assistance are found eligible.

Contacts with medical providers and reviews of claim histories indicated at least ten of the 81 mothers were at high risk due to medical conditions such as diabetes, active herpes virus, infectious parasitic condition, Rh incapatability, liver disease, anorexia, and cervical cancer. Some claim histories and county data strongly suggest psychosocial problems such as substance abuse and family dysfunction.

V. CONCLUSIONS:

It is important to reiterate that the study sample included only those babies born in 1986 who incurred Medicaid costs of $10,000 or more during the first year of life. These 83 babies represented 2.7% of the infants covered by Medicaid during that year. Therefore, we are not speaking about the welfare population in general.

However, by studying the demographics of these infants and their mothers, it becomes evident that the mothers fit a particular profile. Knowing this profile can help us target our energies more appropriately to help those who are most in need.

A. BIRTH WEIGHT:

Over half the babies in the study group were born with low birth weight. The lower the birth weight, the longer time required for the infant to spend in intensive care and, consequently, the higher the medical costs.

According to studies by the Institute of Medicine:

"Low birth weight is a major determinant of infant mortality in the United States. Infants weighing 2,500 grams (5.5 pounds) or less are almost 40 times more likely to die during their first four weeks of life than the normal birth weight infant. In addition, low birth weight survivors are at increased risk of health problems ranging from neurodevelopmental handicaps to lower respiratory tract conditions."

The Institute further reports that:

"Low birth weight infants are also more likely to have significant congenital anomalies than normal birth weight infants. . . They are also vulnerable to the potential side effects of neonatal intensive inpatient hospital care interventions."

The Institute also indicates that when a woman has had a preterm birth or a baby with intrauterine growth retardation (IUGR), the risk of the same problem in subsequent pregnancies increases substantially.

Although the underlying physiological causes of low birth weight are not clearly understood, a large body of information has been developed about "risk factors". These are certain characteristics which indicate an increased chance of bearing a low birth weight infant. The Committee lists six principal risk factors for low birth weight:

I. Demographic Risks
II. Medical risks predating pregnancy
III. Medical risks in current pregnancy
IV. Behavioral and environmental risks
V. Health care risks

VI. Evolving concepts of risk

The demographic risks include:

A. Age (less than 17 or over 34)
B. Race (Black)
C. Low socioeconomic status
D. Unmarried
E. Low level of education

B. AGE OF MOTHER:

The mothers of the high cost infants were characterized by their youth. Nearly three quarters of the mothers (73.9%) were under the age of 25. More than one quarter of the mothers (27.7%) were teenagers.

Studies indicate that young age is not an independent risk factor for low birth weight. Teenage mothers tend to have many other characteristics which increase the likelihood of a low-weight birth. They are more likely to be of a racial minority, of low socioeconomic status, and unmarried than older mothers. Furthermore, they tend to be less educated and more likely to report late for prenatal care.

C. RACE:

Whereas national studies have found Black women to be at higher risk to have a low birth weight baby, in Montana it is the Indian woman who is at higher risk. Again, it is important to note that 80.0% of the mothers in the study group were Caucasian, so this certainly cannot be characterized as a minority problem. However, Indian women were represented in the study group nearly twice as high as the Indian women in the state group.

D. LOW SOCIOECONOMIC STATUS:

The fact that the women were eligible for Medicaid indicates their low socioeconomic status.

The Institute of Medicine reports that:

> "Low socioeconomic status, measured in terms of social class, income, education, or census tract, is clearly associated with an increased risk of preterm delivery and intrauterine growth retardation. The literature suggests that at least some of the excess risk arises from separate factors linked both to low social class and low birth weight. These include smoking, low maternal weight gain and short stature, obstetric complications such as hypertension and preeclampsia (a toxic condition of late pregnancy), some types of genitourinary tract infections, and limited access to high-quality prenatal care. The effect of socioeconomic status probably represents the sum of many

factors, each of which may increase the risk of poor pregnancy outcomes."

E. UNMARRIED:

Again, the study group was characterized by its high number of out-of-wedlock births.

Studies indicate that unmarried mothers have a consistently higher risk of bearing a low birth weight infant than those who are married. Although it is not felt that marital status is linked with either age or race as a risk factor, the Montana statistics indicate that the younger the pregnant woman, the more likely she is to be unmarried.

F. EDUCATION:

Half the women in the study group (50.7%) had not completed their high school educations compared with 14.8% of the state group.

The Committee to Study the Prevention of Low Birth Weight found that "the risk of low birth weight declines sharply among mothers with at least 12 years of education." Their study further indicated that there is a widening gap in low birth weight rates among mothers with different levels of education. They suggest that the poorly educated may constitute an increasingly high-risk group.

G. OBSTETRICAL HISTORY:

The Committee to Study the Prevention of Low Birth Weight (Institute of Medicine) reports that:

> "The history of a woman's previous pregnancies is of prime importance in the prediction of a subsequent low birth weight infant. A detailed study of the weights and gestational ages of all births in Norway from 1967 through 1973 showed that a premature first birth is the best predictor of a premature second birth and that growth retardation in a first pregnancy is the most powerful predictor of growth retardation in a second pregnancy. Previous fetal and neonatal deaths also are strongly associated with preterm low birth weight, and the risk increases as the number of poor fetal outcomes increases.
>
> The effect of the interaction between maternal age and birth order on low birth weight has been well documented. The incidence of low birth weight is high for women between 15 and 19 bearing their second or later child, low for women age 25 to 34 bearing their third or later child, and increases sharply among women having their first child after age 29."

The parity (number of previous pregnancies) of women in the study group indicates that 62.5% of the women under age 25 had at least one previous pregnancy. Data regarding these previous pregnancies is unavailable so it is impossible to determine whether there was an

obstetrical history of premature delivery and/or low birth weight infant.

Other medical problems identified within the study group indicate that many of the women had severe medical problems. From the data collected, it was impossible to assess the behavioral and environmental risks such as smoking, poor nutritional status, alcohol and other substance abuse. According to a report by the Kentucky Coalition for Maternal and Child Health:

> "A mother who receives ongoing medical supervision and counseling during her pregnancy is more likely to receive adequate nutrition, limit the use of tobacco and alcohol, and eliminate any medications not approved by her doctor. All are important factors affecting the outcome of her pregnancy and her delivery."

The report by the Coalition goes on to state that:

> "Children of mothers who do not secure adequate prenatal care are more likely to experience an increased occurrence of mental retardation, birth defects, growth and development problems, blindness, autism, cerebral palsy, epilepsy, and respiratory distress syndrome. Many of these same children may forever be dependent upon society for their care, both as children and adults."

Yet, the data indicates that 66.2% of the women in the study group received inadequate prenatal care, even though the identifiable risk factors were great.

Furthermore, the vast majority of these women were eligible for Medicaid with no incurment (79.7%). However, nearly two-thirds of these women (62.9%) did not apply for Medicaid benefits until shortly before or after the birth of the child.

H. COUNTY OF RESIDENCE:

Because of the small sample size (83 infants), no conclusions can be drawn regarding the distribution according to county of residence. With the exception of the more populous counties, this distribution could be expected to shift from year to year.

VI. REFERENCES:

"Preventing Low Birth Weight, Summary", A report by the Committee to Study the Prevention of Low Birth Weight, Division of Health Promotion and Disease Prevention, Institute of Medicine, National Academy Press, Washington, D.C, 1985.

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"Reaching Women Who Need Prenatal Care", A report prepared by the Health Policy Department, Human Resources Policy Studies Division, Center for Policy Research, National Governor's Association.

"Adolescent Pregnancy in Montana", A report prepared by the Montana Family Planning Program, Health Services and Medical Facilities Division, State Department of Health and Environmental Sciences, 1986.

"Increasing Provider Participation", A report prepared by the Health Policy Department, Human Resources Policy Studies Division, Center for Policy Research for the National Governors' Association, 1988.

RECOMMENDATIONS BASED ON THE STUDY OF

HIGH COST MEDICAID INFANTS

PRESENTED
TO

LEE J. TICKELL, ADMINISTRATOR
ECONOMIC ASSISTANCE DIVISION

BILL HARRINGTON, CHIEF
FIELD AND PROGRAM MANAGEMENT BUREAU

JOHN CHAPPUIS, CHIEF
MEDICAID SERVICES BUREAU

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

BY
PRENATAL CARE COMMITTEE

JANUARY, 1989

SUMMARY

Based on the findings of the study on high cost Medicaid infants, the committee makes the following recommendations for consideration by the Department's Administration:

A. OBRA-Related Options:

1. That "Presumptive Eligibility for Pregnant Women" be reevaluated in 1990.

2. That "Coverage of Poor Pregnant Women and Infants to Age One Year at 185% of Poverty" be reevaluated after the state has expanded coverage for pregnant women to 75% and 100% of poverty, respectively.

3. That "Extended Coverage to Poverty Pregnant Women and Infants up to Age One" be phased in as permitted by federal law and that the resource test be continued. We further recommend that this option be reevaluated at the end of fiscal year 1990 to determine whether increased numbers of pregnant women are being denied Medicaid benefits due to excessive resources.

4. That the "Provider Base for Primary Health Care Services" be expanded to include public health departments or other health care clinics which:

   a. Are under the direction of a physician; and
   b. Provide prenatal health care services.

5. That a "Case Management" system be implemented. Such a system would facilitate early application for Medicaid coverage as well as early and consistent prenatal care services for the targeted high risk group.

6. That "Continuous Eligibility" be further investigated by contacting states that have already implemented this option.

In addition to these OBRA-related options, the committee recommends the following for consideration:

1. That any action affecting Medicaid eligibility or medical assistance to pregnant women in Montana be undertaken with a clear focus on the goal -- namely, the delivery of a healthy baby.

2. That efforts be targeted toward the population which was identified through this study to be at high risk for delivering a low birth weight baby.

3. That a public campaign be initiated to educate all women, particularly the target population, on the importance of early and consistent prenatal care.

4. That the Department of Social and Rehabilitation Services implement and facilitate training workshops for eligibility technicians throughout the state regarding dealing with a pregnant applicant or client.

5. That the Department of Social and Rehabilitation Services work with other interested agencies in making pregnancy-related information available to clients.

RECOMMENDATIONS:

Based on the results of the study on high cost Medicaid infants, the Prenatal Care Committee recommends the following:

A. OBRA-RELATED OPTIONS:

1. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN:

In Montana, AFDC-related Medicaid applications must be processed within thirty (30) days. Checks with counties indicate that a number of counties routinely process such applications within a shorter time period. Whereas the Committee does not wish to discount presumptive eligibility as a viable option, we feel that other alternatives are more appropriate for the targeted population at this time.

Implementation of presumptive eligibility would require a great deal of county support in terms of time and procedural changes. The Committee feels that, prior to the implementation of TEAMS, such a commitment would place a great deal of strain on county offices.

We recommend that the option be reevaluated in 1990.

2. COVERAGE OF POOR PREGNANT WOMEN AND INFANTS TO AGE ONE YEAR AT 185% OF POVERTY:

Although it cannot be determined why one in ten pregnant women in Montana who apply for Medicaid are being denied Medicaid benefits, it is assumed that the inability to meet the incurment may be the major reason for such denials.

The Committee proposes that data on approvals and denials for this population be rerun after fiscal years 1990 and 1991, when coverage for pregnant women has been expanded to 75% and 100% of poverty, respectively.

3. EXTENDED COVERAGE TO POVERTY PREGNANT WOMEN AND INFANTS UP TO AGE ONE:

Whereas expanded coverage is mandated to 100% of poverty by July 1, 1990, states may choose to go to 100% sooner. The use of a resource test for this population is optional.

The Committee recommends that Montana phase in coverage as allowed by federal law -- extending coverage to 75% of the poverty level on July 1, 1989 and 100% of the poverty level on July 1, 1990.

The Committee further recommends that the resource test be kept because the target group is less likely to be affected by its elimination. However, we propose that this option also be reevaluated at the end of fiscal year 1990 to determine whether

increased numbers of pregnant women are being denied Medicaid benefits due to excessive resources.

4. EXPANDING THE PROVIDER BASE FOR PRIMARY HEALTH CARE SERVICES:

The development of case management services for the high risk prenatal clientele will require a comprehensive approach and a primary focus on obtaining quality health care services. Typically, primary prenatal health care services are provided by physicians in private practice. There is a need to provide the private physician with the means of linking the high risk pregnant woman into the case management system.

It is feasible to consider development of prenatal health care services and include case management services under local county health departments available throughout the state. The prenatal services would include the physician or nurse practitioner exam as well as the public health nurse working closely with those clientele who are identified as requiring supervision with management of their prenatal services.

Medicaid could reimburse for exams provided by licensed physicians as well as an established fee for the case management aspects.

5. CASE MANAGEMENT:

The Committee feels that this option bears the greatest consideration given the demographics of the target population and recommends that Case Management be utilized to facilitate:

a. Early application for Medicaid benefits; and

b. Early and consistent prenatal care.

The Committee recommends that the case management facility have a health care focus but also be able to deal with the economic, environmental, and psychosocial elements which may be present. The Committee further recommends that such health care facilities be places where women go for pregnancy testing such as family planning clinics or public health departments.

It would be the responsibility of the Department of Social and Rehabilitation Services to:

a. Provide up-to-date information regarding eligibility criteria and procedures to these facilities;

b. Train case management personnel to assist potential recipients in completing the Medicaid applications and in making appointments at the county welfare offices and to inform potential recipients about materials and information they should bring to their appointments; and

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c. Provide application materials and program brochures and other information, as appropriate.

6. CONTINUOUS ELIGIBILITY:

Recommendations regarding this option could not be made on the results of this study. However, the Committee recommends that, due to the fiscal and administrative impacts, further research be undertaken. Twenty-seven states have chosen this option. We recommend that a sample of these states be contacted to determine how it is working.

B. OTHER RECOMMENDATIONS:

1. That any action affecting Medicaid eligibility or medical assistance to pregnant women in Montana be undertaken with a clear focus on the goal -- namely, the delivery of a healthy baby.

2. That efforts be targeted toward the population which was identified through this study to be at high risk for delivering a low birth weight baby. This population is comprised of unmarried women under the age of 25 who have not completed their high school educations and who are economically deprived. Special attention should be paid to Indian women who fit this profile.

3. That a public campaign be initiated to educate all women, particularly the target population, on the importance of early and consistent prenatal care.

Plans are currently being formulated through the Montana Healthy Mothers/Healthy Babies Coalition to adopt the public information campaign, "Baby Your Baby" which was developed by the State of Utah a few years ago. Through a multi-media approach, the campaign advertises a toll-free number which a pregnant woman can call. (The number is hooked into an answering service 24 hours per day.) The woman gives her name, address, and telephone number and is sent a registration card. Once she completes and returns the card (co-signed by a health care professional), she is sent a gift and informational packet. This packet could contain information regarding:

- Medicaid
- Child Support Enforcement
- Prenatal care facilities
- Other information regarding state agency resources

Two times during the year, a documentary is aired. This documentary is designed to stimulate viewer questions. At that time, the toll-free number is staffed by volunteers who can answer questions and refer callers to appropriate agencies within their communities.

In addition to the documentaries, the "Baby Your Baby" project involves a complete package of public service announcements, billboards, etc.

The professional public relations agency which is developing this package for the Montana Coalition is in the process of seeking financial support for this project from large corporations or other interested entities.

The "Baby Your Baby" project reportedly cost $2.5 million to implement in Utah over a two year period of time. Implementing a similar project in Montana is estimated to cost approximately $300,000. A corporate sponsor would be asked to contribute approximately $75,000 for the two year period.

It is recommended that the State of Montana consider endorsing this project by becoming a corporate sponsor. This would allow coordination of information from all state agencies with a minimum of staff involvement. The media exposure would be far greater than any one agency could hope to gain through conducting its own campaign and the cost would be far lower.

5. That the Department of Social and Rehabilitation Services implement and facilitate training workshops for eligibility technicians throughout the state regarding dealing with a pregnant applicant or client. The training would emphasize the ultimate goal -- healthy babies. The technicians would investigate their attitudes toward unmarried, young pregnant women and would be trained to respond to such women (and, consequently, all other clients) with greater compassion, encouraging prenatal care and referring to a case management team (where such team is operant).

6. That the Department of Social and Rehabilitation Services work with other interested agencies in making pregnancy-related information available to clients. For example, Medicaid brochures could be placed in Family Planning clinics; Check stuffers could be developed for the business offices of providers, informing pregnant women of Medicaid benefits; WIC (Women, Infants, and Children), family planning, and other literature and posters could be placed in county welfare and human services offices.

Community

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June 28, 1989

To the Honorable Max Baucus
and Distinguished Members of the Committee:

I present to you a plea for the establishment of a health care policy for this nation.

The problems of health care in Montana can be transposed to Boston, Philadelphia or Kansas City. The difference is distance, climate and availability of services. The average person with diabetes, Parkinson's or seizure disorders cannot hop on the bus and go across town to the clinic. There are only four "big towns" in the whole state of Montana. There are also not very many clinics.

Until we as a society shift our priorities to education for health promotion and disease prevention and support that concept with both manpower and money, we will continue to go around in circles. Those that would argue the importance of maintaining defense quotas at the expense of health care may soon find that there is very little left to defend.

The family that is not motivated to follow a healthy life style including good communication, high self esteem, pride in education, the value of work and importance of personal responsibility, is playing with a stacked deck. As a society, we need to do all in our power to encourage that motivation. A change of attitude has to occur which attaches significant importance to doing certain things.

The baby born to a 14 year old mother, prematurely, with subsequent debilitating illness is not off to a good start. The fact that the mother had no prenatal care, no real support system, no concept of parenting, let alone education and job potential has not only contributed to the problem, but guarantees that it will be perpetuated.

We will pay for this in spades...probably for the remainder of the child's life as well as the mother. The process of education takes time. We are two or three generations behind and time is running out. As a nation we need motivated individuals in order to maintain our position in the marketplace of the world. You cannot have an increase in productivity unless your workforce is healthy and well educated.

Page Two
June 28, 1989

We need a health care policy. If resources are limited and those that have wealth can get health care and those that don't can't, we have to responsibly and intelligently decide what kind of health care everyone should get. We cannot buy everything for everyone. This will require the cooperative effort of all of us. That may be difficult for many when it affects the pocketbook, but it is because of that pocketbook that we are compelled to do something. Now and soon.

I submit an article by Dr. John Kitzhaber of Oregon, which illustrates and supports my concerns.

Thank you for your attention and consideration.

Marietta Cross, RN

MARIETTA CROSS, R.N.
Administrative Assistant
Maternal/Child Health Care Services

President
Healthy Mothers, Healthy Babies
The Montana Coalition

MC:edn
Enclosure

Special Article

Uncompensated Care—The Threat and the Challenge

JOHN KITZHABER, MD, *Roseburg, Oregon*

Presented at the Annual Meeting of the California Medical Association House of Delegates, March 5, 1988, Reno, Nevada.

The growing crisis in uncompensated health care poses one of the most serious threats facing the medical profession today. If left unresolved, it will not only erode the health of our society and lead to an erosion of the clinical autonomy of physicians, but it will also undermine the very principles on which our health care system has been built. In addition, it will lead to increased regulation of the practice of medicine, and, quite probably, to a government-controlled health care delivery system.

To understand this threat, the challenge it poses, and our critical role in its resolution, we must first consider the evolution of our American health care system.

The health care system we enjoy in this country was founded on the principle of universal access, the idea that all Americans, regardless of their income, should have access to the health care system and to all the services it has to offer.[1] We physicians were able to deliver on this social objective because of our fee-for-service reimbursement system and the ability to cost shift. So when the poor came for treatment, the service was rendered, and the cost was merely shifted to someone who could pay, through an incremental increase in their bill or in their insurance premium.

It is important to realize that this policy was no accident but was the result of conscious decisions in both the public and private sectors. In the public sector, the enactment of Medicare and Medicaid in 1964 extended coverage to the poor and the elderly. At the same time, there was a rapid expansion of private health insurance policies funded primarily through employment. This rapid growth of public and private third-party insurance coverage led to the belief that, in America, health care for the poor was free, when in fact it was being subsidized primarily by the government and by the business community.

Thus, we created what we felt to be an ideal health care system. It was a system with no financial restraints, where individuals had access to as much health care as they needed or wanted regardless of their income. Physicians could practice pure medicine, viewing their patients primarily from the standpoint of their health needs without concerning themselves about their ability to pay. But this system also encouraged utilization and led to the deeply held social belief in this country that health care is a right. Not surprisingly, this resulted in a dramatic increase in expenditures. The amount we spend each year on health care has grown from $75 billion in 1980 to nearly $500 billion today. More telling, however, is the growth of health care expenditures as a percentage of the gross national product: 7.4 cents on the dollar in 1970 versus about 11 to 12 cents today. If this rate of increase were to continue, by the turn of the century we would be spending 20% of the gross national product on health care and by about 2020 we would be spending 40 cents out of every dollar on health care.

Obviously, this rate of increase is not going to continue. While our health care system makes a great deal of sense in terms of a social policy, it makes very little sense in terms of an economic policy. Even a beginning student of economics recognizes that no single set of expenditures can continually grow at a rate faster than the rate of growth of the gross national product. Every dollar we spend on health care is a dollar that cannot be spent on something else. There are many other interests and priorities in which this country must invest.[1]

And while the prosperity we enjoyed over the past 20 years has allowed us to absorb these rapid increases in health care expenditures, it also masked the underlying fallacy of the way health care is financed in this country. By 1980 that mask had been stripped away when a number of factors combined to bring our ideal health care system into a collision with economic realities.

First, new medical technologies were being developed and being used—at a tremendous cost—because the system contained no financial restraints. Second, there has been a significant increase in the elderly as a percentage of the population. The elderly use more health care services than the nonelderly and have a higher incidence of chronic diseases. Both advances in medical technology and an aging population have increased the financial strain on the system.

Two additional factors forced those who had traditionally been subsidizing the cost of health care for the poor—the business community and the government—to reevaluate their ability to continue doing so. The first was the economic stagnation experienced in the United States at the beginning of this decade. While we could absorb the rapid increases in the cost of health care when the economy was growing, it was far more difficult to do so when productivity dropped. Our nation's annual productivity growth was a healthy 3% in the 1960s and 1970s but fell to 0.5% by 1979 and was actually negative in the early 1980s.

The federal budget deficit increased from about $73 billion to $211 billion in five years, and we liquidated all our foreign assets to become the largest debtor nation in the world. By the early 1980s, the government recognized that it

(Kitzhaber J: Uncompensated care—The threat and the challenge. West J Med 1988 Jun; 148:711-716)

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could no longer continue an open-ended subsidy of the cost of care for the poor without raising taxes, increasing the deficit, or making deep cuts in other domestic programs. The government became interested in cost containment to balance the budget.

At the same time, this country entered the world market. American businesses began recognizing that they were no longer competing just among themselves, as the auto industry once did; they were competing with mainland China, West Germany, Japan, Italy, and Canada. They realized they had to cut costs, particularly labor-related costs, in order to remain competitive with cheap labor industries abroad. They could not, for example, just pass the cost of health care on to their consumers and still remain competitive in a world market, particularly when American businesses had to carry the cost of health care on their books as a necessary expense and were competing with companies that did not have to carry employer-sponsored health care programs. The business community became interested in the need to contain costs to remain competitive.

This brought about very similar responses by both the government and the business community. The objective was simply to reduce the exposure to the cost shift and reduce the funding and subsidy of the cost of providing health care for the poor. It should be noted that the subsidy was not taken out of the system, it was merely shifted onto individuals and providers. Here is how it was done.

In 1983 the federal government enacted DRGs [diagnosis-related groups], a prospective reimbursement system that shifted economic risk onto providers. The federal government also began requiring first-day hospital deductibles for those on Medicare and increasing the Part B monthly Medicare premium that pays for physician services. This shifted costs onto the individuals. With Medicaid, the program for the poor, the federal government cut its match rate and shifted that to the states.

The first thing the states did was cut provider-reimbursement rates. Physicians currently average 45 to 50 cents on the dollar for taking care of someone on welfare. That pushed costs and responsibilities onto the providers. When that did not balance the budget, the states increased the requirements for Medicaid eligibility, which pushed people off the program altogether. That shifted responsibility to the individuals. In the past ten years, 800,000 women and children have been squeezed off Medicaid, and the program, which used to cover 65% of the poor, today covers less than 38%.

The private sector reacted in exactly the same way, with increased involvement in health maintenance organizations, preferred provider organizations, and other prospective managed care plans that put providers at risk. Businesses increased copayments and deductibles for their employees that shifted costs onto individuals.

The [illegible] sector, [illegible] that of [illegible] community. There was a recognition that the amount of money that could be spent on health care for the poor was limited, but there was no consideration of the implications of those decisions on access to health care. [illegible] system.

Today, our health care system is in transition. We are still ostensibly committed to the principle of universal access, but now the system is driven by economic factors, not by the social factors that drove it in the 1960s and the 1970s. Providers are at economic risk. We are losing the ability to cost shift.

As I mentioned earlier, our ability to deliver on the principle of universal access has depended on cost shifting and the willingness of the business community and the government to subsidize the cost of care for the poor. While there is still supposedly a commitment to universal access, we are seeing a progressive shifting of the responsibility to pick up that cost. Between 1965 and 1980 that subsidy was borne by the government and by employers, who spread it out over taxpayers in general and over most of the workforce. Society was paying for what was essentially a social policy objective: universal access to health care.

Because of the cost-containment measures that have occ[illegible] shifted onto providers, who have far less ability to absorb it. What used to be subsidized care for the poor is now showing up as uncompen[illegible] point where they cannot absorb additional uncompensated care and still pay the bills, they push the costs onto individuals. And, today, if a person does not have insurance coverage and does not have money, that person is increasingly likely to lose access to the health care system, either because providers will not accept any additional indigent patients or the patient delays treatment because of an inability to pay for it.

This has dramatically changed how health care is financed in this country. Our health care system has traditionally had a bifurcated financing mechanism. On the one side is the public system, which is Medicare and Medicaid. On the other side is the private system, which is mostly employment-based policies and some individual policies. There has always been a little gap in between where some people slipped through the cracks. But as long as the government and the business community were willing to subsidize the cost of care for the poor, that gap has been very narrow and has really contained only society's truly downtrodden.

Today, however, those two third-party payers, government and business, are trying to escape from the subsidy. As we see a reduction in government expenditures, the growth of copayments and deductibles in Medicare, and increases in Medicaid eligibility, people spill off the public side into the gap. As competition in the world market increases, as we shift from a manufacturing to a service-based economy with large numbers of low-paid, nonunionized workers without health insurance coverage, and as premium rates go up, people spill off the private side and into the gap. Today, the gap is not narrow; it contains 37 to 40 million Americans. And they are not [illegible] just society's truly downtrodden. Of those uninsured people, 70% are working full time or part time or are dependents of someone who is working. These in the [illegible] 95% of the uncompensated care.

Why should we be concerned about this shifting responsibility to pay for the care of the poor? We should be concerned because there are some serious social consequences affecting all of us, and some serious professional consequences affecting physicians in particular.

The first social consequence is an erosion in our commitment to universal access. Because there is a physician surplus in the country, and because care for the poor is no longer subsidized but is uncompensated, we have a very competitive, market-driven system in the provider community. And

since market systems were not designed to foster social responsibility, it should not be surprising that no one is compensated for uncompensated care. Public health clinics are closing. We are seeing patient dumping from hospital to hospital, physician to hospital, and between physicians. There are treatment delays. And there are a growing number of people in the gap.

That leads to the second social consequence, which is a very real and measurable deterioration of health for a growing number of Americans. We have 40,000 neonatal deaths each year from the complications of low birth weight. Two thirds of those mothers do not receive adequate prenatal care. Of the poor in America, 40% are children. Only a third of them are covered by Medicaid; the other two thirds are in the gap and are losing access to basic preventive services. We are seeing an increase in cases of pertussis and increases in pediatric nutritional problems. There is case after case of people actually dying because of a lack of access to the system—people dying of strokes because they could not get their blood pressure medication prescription refilled; people dying of heart failure and having myocardial infarctions because of a lack of routine checkups or medication; and people dying of perforated ulcers because of treatment delays.

The third and perhaps most serious social consequence is that we are mortgaging our own future. I think this is very important and would ask you to bear with me for a moment. As I mentioned, 40% of the poor in this country are children, and two thirds of them are in the gap with no insurance coverage. Also in that gap are tens of millions of young working Americans. These people constitute a large part of the shrinking workforce of tomorrow that we are expecting to fuel the economy and pay for a growing retired population. How are they going to do that in the face of $170 billion owed to foreign governments and nearly a $3 trillion national debt? How are they going to do that in the face of a $10 trillion unfunded liability, the difference between what we expect them to make and what we are planning to take out of their paychecks to pay for Medicare, Social Security, and federal pensions, most of which are automatically indexed to inflation and do not have income eligibility requirements? We are asking them to do something that we have all refused to do: to recognize that increases in personal consumption have to be balanced with increases in productivity.

In the past ten years, American workers have averaged a $3,100 increase per capita in personal consumption and only $950 of that has been paid for by increases in what each one produces. The remaining $2,150 has been paid for by cuts in domestic spending and investment and by foreign debt (P. G. Peterson, *The Atlantic Monthly*, Oct 1987, p 47). We are asking this group of people to be more productive than anyone in the history of this country and to probably take a reduction in their standard of living. Having asked them that, we are crippling them going in, by denying them access to the basic health care services they need to be healthy, productive members of the workforce. You cannot have an increase in productivity unless your workforce is healthy and well-educated. That is a very, very serious implication.

There are also some disturbing professional implications. The first is that the growing problem of uncompensated care is catching physicians between what society expects from our health care system and economic realities. When the government and the business community moved to limit their subsidy of the cost of health care for the poor, they could do so without denying access to individuals and without publicly or explicitly abandoning the idea of universal access because they shifted that subsidy onto the providers. But when physicians move to limit their exposure to this subsidy, and for exactly the same reason, they have to deny access to individuals. When physicians reach the point where they cannot absorb any additional uncompensated care, they either have to reduce the number of indigent patients they see or reduce the services they provide to those patients. In either case, that means rationing. Increasingly, physicians in this country are being forced to become the rationing instruments for a society that refuses to recognize that rationing is occurring.

That puts us in direct conflict not only with our professional ethics but with social expectations for the health care system. It casts us in a very unfavorable light. Many people still view physicians as we were seen in the halcyon days of the 1960s and 1970s when the economy was booming and incomes were rising. Most legislators are not physicians—I am the only physician in the Oregon legislature. Many legislators do not understand the relationship between cost shifting and subsidizing care for the poor, and do not understand the implications of taking cost shifting away from providers.

The thought that a wealthy profession would be denying access to the poor is unacceptable to most legislators, a fact that puts physicians in a very vulnerable position politically. As the problems of the poor intensify, state legislatures are going to begin to react. They are going to say, "If you physicians are not going to take care of the poor voluntarily, we are going to force you to do so." There are many ways that coercion can be accomplished.

As a condition of licensure, physicians can be forced to take care of a certain number of indigent patients. That bill was actually introduced in Oregon last year. A gross income tax can be applied to physicians' earnings to help pay for indigent care. That bill was introduced in Washington in 1985 and has been considered in Pennsylvania. These types of intrusive regulatory measures are being introduced in state legislatures across the country. Unfortunately, all they do is force physicians to assume the fiscal responsibility for taking care of the poor. They ignore the fact that society, while paying lip service to universal access, has made a decision to limit the amount of money that will be spent on health care. The problem remains unresolved. When someone convinces corporate America that a government-sponsored health care program will put them in a better position in terms of competition in the world market, then we will be looking at a nationalized health care program. In the short run, we are looking at increased regulation and an erosion in our own clinical autonomy.

What do we do about this problem? To solve this crisis in uncompensated care, we have to start by accepting three hard realities.

The first reality is that resources are limited. That is a difficult one for physicians to accept because they have never had to accept it. But it should be obvious to anybody who looks at the need in this country and looks at the available dollars.

We have a national debt approaching $3 trillion that we must reduce. We have a huge defense budget that has been traditionally hard to pare down. We spend $450 billion a year on Medicare, Social Security, and other federal pensions. At the same time, we are cutting aid to education and invest-

ments in roads, bridges, sewers, and water systems. We are cutting civilian research and development. We are cutting all of the things we need to increase the productivity in this country.

No one wants their personal health care expenditures cut. At the same time, however, we want to reduce government spending, we want good roads and schools, safe streets with criminals behind bars, a comfortable retirement, police protection, fire protection, clean air, and clean water. And we want to do all that, of course, with lower taxes and higher wages.

Now, obviously that does not work. There is a finite amount of money that this country can invest in health care versus the other things that we also have to invest in. Once we come to grips with the fact that there is a finite health care budget in America, then we have to decide who is going to get the service and how much service each person is going to get.

That brings us to the second reality, which is simply that the rich are always going to have access to more health care than the poor. I think that is probably all right if what the poor get is adequate and if they are all getting it. After all, one of the hallmarks of a capitalistic system is that goods and services are distributed on the basis of income, not necessarily on need or merit. We readily accept that in most instances. We do not expect public housing to look like the Ritz. We do not expect food stamps to be redeemed in expensive restaurants. But because of our concept of universal access, we have taken for granted that the poor should have access to all the health care services that are available to the rich. I would remind you that this is the only part of our system that operates on this open-ended economic principle. We have in effect rejected a multitiered system based on income, but in reality we already have that kind of a system. The rich have always been able to fly to other states and other countries for diagnostic and therapeutic modalities not available at home. The rich have had consultations and elective operations to which the poor have not had access. So what we have really is a poorly defined definition of what we think everyone has a right to and what perhaps they do not have a right to.

I think we would all agree that everyone should have a right to prenatal care, but we may argue whether or not the public should pay for an elective face-lift for everybody on welfare. The question becomes much more difficult, however, when we are trying to balance a transplant versus prenatal care.

We need a better definition of adequate health care to address that question. If we know resources are limited, if we know people with higher incomes can buy more health care than people of lower incomes, and if we know that society cannot buy everything for everyone who might benefit from it, we must consciously and responsibly decide what level of health care everybody should get. That means defining adequate health care and brings us to the third reality.

The third reality is the inevitability of rationing. This is also a very difficult concept for physicians to come to terms with, but when you define adequate health care, you also define what is more than adequate. And that provides the basis for the explicit rationing of health care. Before we overreact to this reality, I would suggest that rationing already exists in our system. We clearly already ration by income and by transportation barriers. More important, however, we ration inadvertently through legislative decisions because we lack any policy to guide how our health care dollars are spent. Rationing is the result of limits. If there is a limited amount of money in the health care budget and it is spent on one set of services, it is not available to be spent on another set of services. That is rationing.

Consider how this is being done today. Almost $2,000 per capita is spent each year on health care in America, far more than any other country in the world. Yet our wellness, as measured by morbidity and mortality statistics, is not significantly better than that in England, which spends $500 per capita, or even Singapore, which spends only $200 per capita (R. Lamm, "The Ten Commandments of Health Care," speech given at the Midwest Health Conference, Kansas City, Mo, March 28, 1988).

Why? Because we have no policy to guide how we spend our health care dollars. We are spending huge sums on some and we are spending virtually nothing on others. We spend more per capita on health care than any other country in the world, yet 37 million Americans have no coverage and many of them are losing access to the system. We spend $3 billion a year on neonatal intensive care while denying prenatal care to hundreds of thousands. We spend $50 billion a year on people in the last six months of their lives while closing pediatric clinics.[3]

That is like having someone in charge of a corporate truck fleet who adopts a policy that the oil in the trucks will not be changed until the engine blocks melt. The trucks won't be maintained but will be serviced only when there is a major breakdown. I doubt if you would endorse this policy for your car, nor would you employ anyone who did, but that is exactly how we spend health care dollars in this country. Rather than spending money on prenatal care, we spend it on neonatal intensive care. Rather than treating hypertension, we treat people who have had strokes. We are rationing by default, unguided by any social policy. It is inequitable, inefficient, and we are wasting millions of dollars and thousands of lives. The reason we are rationing implicitly as opposed to explicitly is because we do not want to come to grips with our own limits.

To solve the problem of uncompensated care, with all of its ominous implications for society and for physicians, we have to recognize that our health care system is indeed in flux and that we have to build a new system based on the three realities that I mentioned: limited resources, acceptance of the fact that the rich will always be able to buy more health care than the poor, and the need for rationing.

We have to recommit ourselves to universal access—not universal access for everyone to everything—rather, universal access for everyone to an adequate level of health care. That will put our system back on a sound economic foundation. It also means that we are going to end up in this country with a three-tiered system of delivery. In reality we already have a nondefined, implicit multitiered system: the medically indigent, Medicaid, workers with insurance, the wealthy. What I am suggesting is that we stop pretending it doesn't exist, accept its inevitability, and take steps to make it work equitably and efficiently. This would mean a government-sponsored tier for the poor, a tier that the business community funds for those who are working, and a traditional fee-for-service tier for those who wish to buy additional health care services.[4]

I want to reiterate one point. The government has a responsibility, in my mind, to pay for the poor but not for the elderly unless they are also poor. The government should pay

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for the poor regardless of their age. There is no reason Lee Iacocca needs Medicare, or Johnny Carson, or even my parents. Government-subsidized health care programs should have income eligibility requirements.

This is important because it is at the first, or public, tier that we have to come to grips with rationing. It is at this tier that we must set the socially acceptable minimum level of health care for this country. How do we get there?

Let me describe what is being done in Oregon, where we are attempting to resolve this problem. There are three elements involved: first, a clear social policy; second, a definition of adequate health care; and third, a universal insurance system to guarantee that people get access to that care.

Because of my time constraint, I will only cover the first two elements. Concerning universal health insurance coverage, however, let me say that while it is an essential component of the final solution, it is putting the cart before the horse. We need to recognize that the objective of our social policy of the 1960s and 1970s was, in fact, universal access. One of the reasons we are in trouble today is that we were, in the short run, able to cover everybody for almost everything. But unless we first define the level of care for which people are universally covered, we still have an open-ended system that we cannot afford.

Therefore, we first need a clear social policy to ensure that we spend our limited health care dollars in a way that is efficient and equitable. In Oregon we have made an attempt to recognize our limits and to adopt such a policy. In the past legislative session, we discontinued funding for heart, pancreas, bone marrow, and liver transplants for people on welfare and used that money to extend preventive and prenatal services to a far larger group of people who had been in the gap. This constituted an explicit rationing decision. Let me go over the issue we were dealing with because, I assure you, it has not been an easy one to defend, politically or as a physician, although I firmly believe that it was the correct decision given the reality of limited resources.

The question was not whether transplants have merit; clearly they do. The issue was not whether in the short run we could find some additional money to buy a few more transplants for people on public assistance; clearly we could have. The issue was simply that if we were going to put additional money into health care, where was the best place to spend the next available dollar? Did it make more sense and was it a better use of limited public funds to buy high-tech services for a group of people (those on Medicaid) who already had access to virtually everything available in the private sector, or to extend services to a larger number of people who were in the gap, many of whom did not have access to any health care whatsoever?

We felt it made more sense to serve the larger number of Oregonians. Thus, the policy adopted in Oregon is one of universal access to adequate health care, and we have made that the first priority for spending the additional dollars that we can get into our health care budget. That still leaves the second element: defining adequate health care. Oregon's definition at this point does not include major organ transplants because we have made a decision that they are of a lower priority than preventive care. But we do need a more complete decision.

Before I describe to you the process we are using in Oregon to arrive at that decision, let me say that once you get a definition of adequate health care and array your health care services on a priority basis, you are changing, in a fundamental way, the nature of the rationing debate. The rationing debate traditionally has an individual focus, and it goes like this. We have one heart and three potential recipients. Do we give that heart to a 17-year-old unwed mother of three on welfare, do we give it to a 35-year-old man serving time for rape and armed robbery, or do we give it to a 40-year-old corporate executive?

This scenario raises the kinds of imponderable ethical and moral questions that society, almost by definition, cannot resolve on an individual basis. But once we develop a definition of adequate and array our health care services in a priority order, we shift that debate from an individual focus to a societal focus. We are no longer debating which service should be given or denied to which person, we are debating which priority of funding should be given to each service, given the reality of limited resources. Because society has made the decision to limit the amount of money it spends on health care, society needs to make the decision on how to spend that money. In addition to providing basic health care to a far larger number of people, this approach also takes physicians out of the squeeze and allows them to continue to be patient advocates. They can continue to do everything they can possibly do for their patients within the context of the resources that society has made available.

How do we get to this definition of adequate? There are really three steps. The first and probably the most difficult is building a consensus. In Oregon we are working with a group called Oregon Health Decisions, founded in 1982 by Ralph Crawshaw, MD, a Portland psychiatrist. It is a private, nonprofit group dedicated to educating Oregonians on the health policy choices and confronting them with the consequences of those choices. It was the first such group in the country. Now 14 states have similar organizations, including an active one in California.

We have appointed a steering committee of which I am the chair. We are breaking down everything on which Oregon currently spends its health care dollars. We are making a decision package for each service with a summary document that describes the number of people getting the service and the cost, the number of people not getting the service and the economic and health implications of not giving them that service, and then the cost to extend the service to everybody in the unmet-need population.

The plan over the next few months is to arrange this list in a tentative priority order and take it out to town hall meetings around the state of Oregon where citizens can actually get involved in working through the trade-offs and choices necessary to set up a priority list of health care choices, given the fact of limited resources. We will bring that information together this fall to generate a final list that will be submitted to the legislature.

Once the health care resources are arrayed in that kind of priority list, we come to the second step, which is to integrate this information with the legislative budget process. This requires that funding go to the first item on the priority list for everybody in the population for whom the state has responsibility. Going down the list, the second item is fully funded before moving to the next, then the third, the fourth, and so on, until the available money is exhausted.

This process puts accountability into the system. If, for example, a state legislature decides to cut $20 million out of the health care budget, it will no longer be an abstract ac-

counting exercise but will mean deleting specific services for specific individuals off the bottom of the priority list. The debate becomes far more focused. If someone wants to re-fund the transplant program, clearly they either have to knock something else off the priority list—and they must make a choice, a clinical choice and a political choice, between those two health care services—or they have to rob another program or raise more money (increase taxes).

The final point with this type of system is that if it is done on the basis of sound clinical information, money can actually be saved. A California obstetrics-access study suggested that the cost of treating an indigent woman for prenatal care and delivery was $1,000 and the cost of treating a low-birthweight infant was $28,000, up to six figures. The study suggested that if prenatal care were provided to all the indigent women who needed it, $22 million a year could be saved in the health care system. That is money that can be used to add services on the priority list, such as major soft organ transplants. It could be used to raise provider reimbursement to a reasonable level and thus remove the current economic disincentive to treat the medically indigent and those on Medicaid, or it could be used for roads. In any event, the debate becomes much clearer and more focused. Accountability is inescapable.

What is the role of physicians in resolving this problem? The first and most significant role we have to play is that we must come to grips with our own limits. We have to recognize that health care resources in America are, in fact, limited. If the leadership of professional medical organizations is going to publicly refuse to recognize that health care resources are limited, how can we expect the public to accept that, and how can we expect state legislatures to recognize that as well? If we are not willing to recognize this ourselves, we are inviting all of the ominous social and professional consequences that uncompensated care is bringing our way. As a first priority, therefore, physicians must recognize and accept limits in health care, express that view publicly, and talk it over with each other and with their patients.

Second, through our professional organizations we need to adopt policies on how to expend limited public health care dollars. Your society or association may already have such a policy but, if not, I would suggest one that states that the first priority should be to extend an adequate level of care to everyone. Then, and only then, should we indulge ourselves in the debate over how to spend what is left in the budget.

This means, of course, that we must also get involved in the definition of adequate. Physicians are really the only group in this country with the qualifications to provide sound clinical information to the state legislature. We need to say: "Yes, we are going to have to ration health care in this country. It is inappropriate and unethical for physicians to do the rationing; society needs to do it. And if you, the legislature, are going to ration health care, here is a list of priorities that make sense clinically. This makes sense in terms of marginal costs and marginal benefits. This makes sense in terms of probable outcome." Physicians have to provide that input. Then we have to support legislative decisions that make responsible resource allocation choices. We have to do that publicly, in our community, and at the legislative level.

This, then, is the threat and the challenge of uncompensated care. The solution, I believe, is a partnership between public policymakers at the state legislative level and leadership in the medical community. If left unresolved, this problem of uncompensated care is going to result in an erosion in our social commitment to universal access to health care and a deterioration of health for a growing number of Americans, with very serious social and economic consequences. It is going to put physicians in conflict with their professional ethics and with what society expects from the health care system, which will lead to regulation, an erosion of clinical autonomy, and very likely a nationally controlled health care delivery system. We need not accept this outcome. In fact, we cannot accept this outcome. With the active involvement and leadership from the medical community, we can meet this challenge and restore some rationality and equity and economic stability to our health care system.

I ask you to join me in meeting that challenge.

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NATIONAL CLEARINGHOUSE
FOR ENDING SEX DISCRIMINATION IN INSURANCE

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TESTIMONY FOR JUNE 28, 1989 HEARING
OF BIPARTISAN COMMISSION FOR COMPREHENSIVE HEALTH CARE

Marcia Youngman, Director, National Clearinghouse for Ending Sex Discrimination in Insurance, a program of the Montana Women's Lobby:

The causes of American's growing problems with health care availability and cost are complex, and a comprehensive solution will involve many needed changes. One simple but significant move in the right direction is to end sex discrimination in insurance.

Health insurance costs are skyrocketing. Women and their families are the hardest hit. Working women, including the growing number of single parents, tend to be concentrated in jobs that do not provide health insurance as an employee benefit, and are much more likely than men to need to purchase it in the commercial market. Women still earn an average of $.60 for every dollar a man earns ($.50 in states like Montana), and thus have much lower buying power. Low-wage working women, part-time working women, women in small businesses, self-employed women, and farm women are among those in particular need of affordable, individual insurance policies. Women on welfare list the cost of health insurance as one of the top two barriers, along with child care, to entering the workforce.

Insurance industry representatives often quote a statistic showing that over 90% of people receive their health insurance through places of employment rather than privately. This statistic is seriously misleading because it only deals with people who are insured and ignores the millions of uninsured people, who, for the most part, would purchase health insurance if they could afford it. It also ignores the reality in rural states. In Montana, for instance, only 37% of non-military workers receive health insurance as a benefit, according to a survey of the Employee Benefit Research Institute. Less than half of these covered workers are women.

Policies provided by employers with 15 or more employees must be gender-neutral, but small group and individual policies are still gender-based. Except for a few years before age 65, women are charged as much as several hundred dollars a year more for these policies than men, and are less completely covered. Paying more and receiving less causes women and families significant economic hardship.

*Health problems and needs predominantly or exclusively experienced by men are more likely to be covered by health insurance than those conditions wholly or chiefly experienced by women. For example, vasectomies, prostate surgery, sports injuries, and alcohol-related diseases are usually covered, whereas anorexia, birth control, tubal ligations, and maternity often are not.

* Maternity coverage is routinely excluded, unless people pay for an expensive rider that commonly costs over $900 a year and then typically covers less than half of the average cost of a normal delivery. Women may have the babies, but pregnancy certainly involves both sexes, and it is furthermore in society's interest that healthy babies be born. Pre-natal and well-baby coverage often requires purchase of an additional rider. Poor pre-natal care, most common among those who cannot afford it, has a direct relationship to low-birthweight

babies, which involve an average hospitalization cost of $15,000 and often a continuing legacy of health and learning problems. Either the family or the taxpayer bears the burden of these largely avoidable costs.

Montana was the first state to comprehensively eliminate sex and marital status discrimination in insurance and annuities through legislation which passed in 1983 and took effect in 1985. Massachusetts has since joined Montana through its regulatory process, and gender-neutral insurance will be a requirement in Pennsylvania by March, 1990 as a result of ERA-based litigation. The Montana Women's Lobby, a coalition of 52 statewide groups which works to improve the economic and social status of Montana women and children, championed Montana's landmark law and established a Non-Gender Insurance Project after its passage to study economic impacts on consumers and companies. We found the impacts to be largely positive, with women and families gaining significantly and no companies led to cease doing business in the state due to the law.

Charts are attached showing the average annual impacts on women's, men's, and family policies. We surveyed the top insurers in the state for four deductibles--$250, $500, $1,000, and $2,000--and three age categories--30, 45, and 60. The survey showed over 84% of families, women, and men experiencing rate decreases in health insurance. At a time when health insurance was skyrocketing in other states, Montana's market became more competitive, with generally more affordable health insurance. Women and couples, with and without children, were the primary beneficiaries. For instance, a single mother with two children averaged a 16.6% annual decrease ($221.83) across all four deductibles. This figure and the attached charts do not reflect the additional savings ($900 annually for a maternity rider) the law caused by eliminating the exclusion of maternity coverage from policies. Over a lifetime, women were paying an average of $5,256 more than men for the same health insurance policies, not counting maternity rider costs, so the savings is significant, especially when you consider the time value of all the money saved.

An additional impact of gender-neutral insurance that relates to health care is on disability income insurance. The major disability insurers established gender-neutral rates several years ago to attract the growing number of women professionals with more affordable rates. However, policies offered to people in blue and pink collar jobs and policies offered by smaller insurers remained gender-based in many cases. Furthermore, one of the major insurers has just returned to using gender-based rates, and others are considering this move, even though during this period women's share of the disability market climbed steadily from 9% to 23%. Gender-based disability income insurance can cost a woman as much as 100% more than a similarly situated man. Our study showed disability insurance costing a woman $7,100 more than a man over her purchasing lifetime.

The insurance industry claims that women are more expensive to insure in both health and disability insurance. It has not been scientifically proven that there's anything about women that make them inherently more expensive in these categories. In fact, the National Center for Health Statistics shows women to have lower average annual hospitalization stays, pregnancy excluded or included. It is likely that temporary maternity disability, and perhaps primary caregiving responsibility for children and elderly parents, is skewing the industry's data on women. Furthermore, the insured population can't be considered a representative sampling of Americans. We have seen no studies by

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the industry using a control group of uninsured people, and, in fact, we have seen no studies at all from the industry but have just heard a variety of undocumented claims that sound more like social stereotypes than solid data. It may be that in a category like disability, women have become temporarily more expensive to insure, though we have seen no evidence that this is even true. However, women insured for the first time may have put off addressing serious health problems through operations or in other ways until covered by disability insurance, so this could throw off the accuracy of data collected in recent years.

Regardless of relative costs for women and men in the various categories of gender-based insurance, we consider the use of gender as a rating factor to be a violation of people's civil rights. The inconsistent or unscientific use of actuarial data (and the use of gender as a selection factor for types of problems covered) in ways that tend to penalize women in every category of gender-based insurance makes this particularly clear.

We would like to make one last point regarding the possibility of mandatory health coverage through a bill such as S.768, which would decrease the number of uninsured and reduce the need for private health insurance. Such coverage would be gender-neutral, but to benefit low-wage working women and families, such an approach must include part-time workers and must not have a negative financial impact on people living near poverty level. Many low-wage workers work full time at two part-time jobs of 17-20 hours a week each, and would be left out of a plan that only covers jobs involving 25 or more hours a week. People living slightly above poverty level still have trouble meeting basic food, rent, clothing, and transportation costs. For people working at less than 125% of poverty, any premium sharing, deductibles, or copayments for health coverage would be an insupportable financial burden. For people working at 125-185% of poverty, a sliding scale for these costs might make sense, so people's share of the costs would rise in proportion to increases in wages. If these considerations are not taken into account, the large number of low-wage working women and families could be harmed more than helped.

Thank you for this opportunity to testify. Please let me know if I may be of help by providing further information about the impacts and need for gender-neutral health and disability insurance.

AVERAGE ANNUAL MONTANA RATES FOR COMPREHENSIVE HEALTH PLAN

$250 DEDUCTIBLE

Policy Holder	April '85	April '86	$ Change	% Change
AGE 30				
Single Female	$912.73	$664.86	-$247.87	-27.16%
Single Male	$639.15	$664.86	$25.71	4.02%
Family	$2265.17	$1888.18	-$376.99	-16.64%
AGE 45				
Single Female	$1193.03	$967.68	-$225.35	-18.89%
Single Male	$936.19	$967.68	$31.49	3.36%
Family	$2833.41	$2478.24	-$355.17	-12.54%
AGE 60				
Single Female	$1539.17	$1473.41	-$65.76	-4.27%
Single Male	$1583.25	$1473.41	-$109.84	-6.94%
Couple	$3059.96	$2887.04	-$172.92	-5.65%

AVERAGE ANNUAL MONTANA RATES FOR COMPREHENSIVE HEALTH PLAN

$500 DEDUCTIBLE

Policy Holder	April '85	April '86	$ Change	% Change
AGE 30				
Single Female	$712.19	$539.26	-$172.95	-24.28%
Single Male	$563.60	$539.26	-$24.34	-4.32%
Family	$1756.33	$1513.25	-$243.08	-13.84%
AGE 45				
Single Female	$936.00	$782.87	-$153.13	-16.36%
Single Male	$725.03	$782.87	$57.84	7.98%
Family	$2191.25	$1983.97	-$207.28	-9.46%
AGE 60				
Single Female	$1217.40	$1195.21	-$22.19	-1.82%
Single Male	$1251.96	$1195.21	-$56.73	-4.53%
Couple	$2410.72	$2333.16	-$77.56	-3.22%

AVERAGE ANNUAL MONTANA RATES FOR COMPREHENSIVE HEALTH PLAN

$1000 DEDUCTIBLE

Policy Holder	April '85	April '86	$ Change	% Change
AGE 30				
Single Female	$579.77	$446.21	-$133.56	-23.04%
Single Male	$415.39	$446.21	$30.82	7.42%
Family	$1417.77	$1273.69	-$144.08	-10.16%
AGE 45				
Single Female	$768.69	$649.83	-$118.86	-15.46%
Single Male	$609.62	$649.83	$40.21	6.60%
Family	$1798.73	$1752.89	-$45.84	-2.55%
AGE 60				
Single Female	$1001.87	$991.21	-$10.66	-1.06%
Single Male	$1029.76	$991.21	-$38.55	-3.74%
Couple	$1973.11	$1925.48	-$47.63	-2.41%

AVERAGE ANNUAL MONTANA RATES FOR COMPREHENSIVE HEALTH PLAN

$2000 DEDUCTIBLE

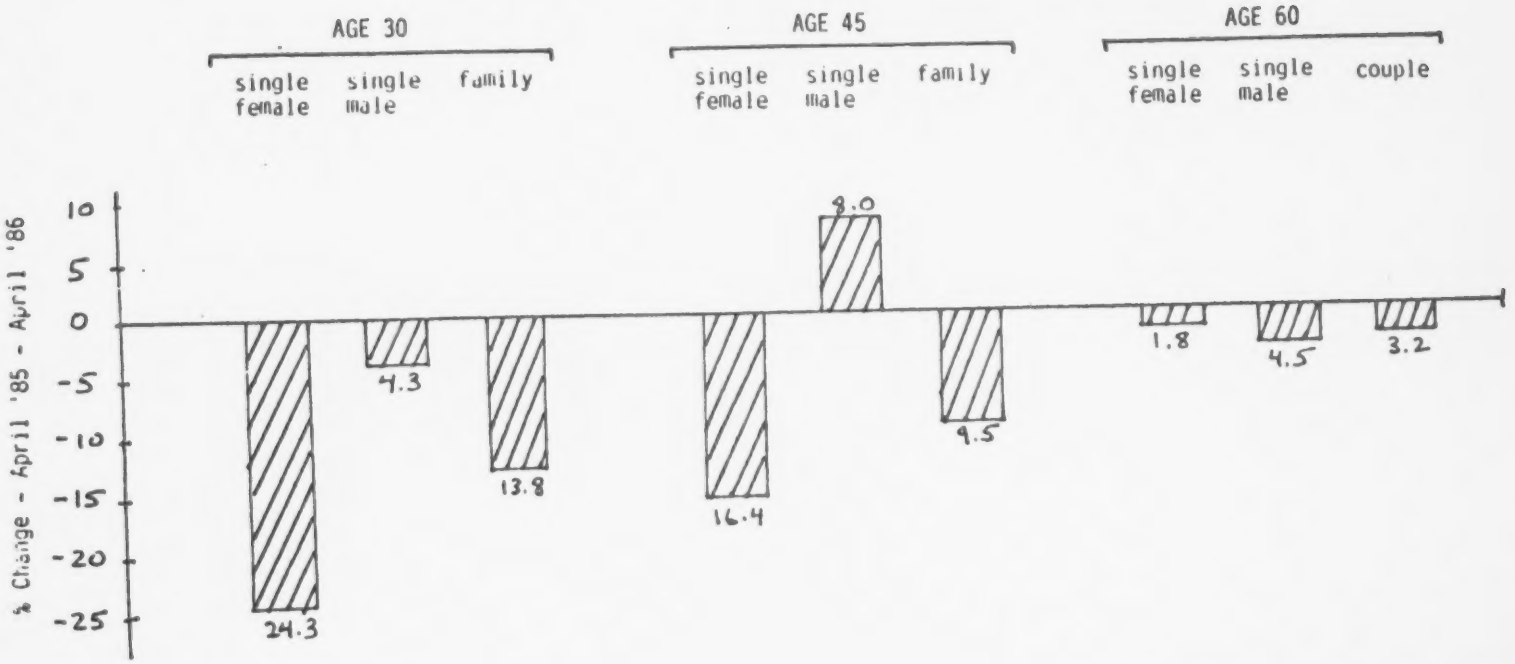
Policy Holder	April '85	April '86	$ Change	% Change
AGE 30				
Single Female	$426.08	$343.02	-$83.06	-19.49%
Single Male	$327.24	$343.02	$15.78	4.82%
Family	$1114.82	$973.24	-$141.58	-12.70%
AGE 45				
Single Female	$564.24	$508.58	-$55.66	-9.86%
Single Male	$418.38	$508.58	$90.20	21.56%
Family	$1391.66	$1304.38	-$87.28	-6.27%
AGE 60				
Single Female	$739.14	$751.81	$12.67	1.71%
Single Male	$765.32	$751.81	-$13.51	-1.77%
Couple	$1477.19	$1462.75	-$14.44	-0.98%

AVERAGE ANNUAL MONTANA RATES FOR COMPREHENSIVE HEALTH PLAN

Single Woman, Aged 30, with two Children				
Deductible	April '85	April '86	$ Change	% Change
$250 Ded.	$1655.27	$1286.54	-$368.73	-22.28%
$500 Ded.	$1282.97	$1050.88	-$232.09	-18.09%
$1000 Ded.	$1044.14	$866.75	-$177.39	-16.99%
$2000 Ded.	$814.85	$671.14	-$143.71	-17.64%

Single Woman, Aged 45, with two Children				
Deductible	April '85	April '86	$ Change	% Change
$250 Ded.	$1920.88	$1570.15	-$350.73	-18.26%
$500 Ded.	$1498.80	$1260.29	-$238.51	-15.91%
$1000 Ded.	$1225.53	$1074.59	-$150.94	-12.32%
$2000 Ded.	$953.02	$836.71	-$116.31	-12.20%

$500 DEDUCTIBLE MAJOR MEDICAL POLICY - AVERAGE ANNUAL PREMIUM



NON-GENDER INSURANCE PROJECT

of the Montana Women's Lobbyist Fund
1214 W. Koch • Bozeman, Montana 59715 • (406) 587-5704

Project Director, Marcia Youngman

September, 1987

FACT SHEET ON MONTANA'S NON-GENDER INSURANCE LAW

Montana's landmark comprehensive law prohibiting gender and marital status discrimination was passed in 1983 and took effect October 1, 1985. At that time, the Women's Lobbyist Fund established the Non-Gender Insurance Project and began a study to monitor the impacts of the law on auto, health, and life insurance and annuity rates and paybacks. A summary of the results of our study is included in this fact sheet. We are very encouraged by the results. Even in the first transitional months of rate adjustment, a significant pattern of public benefit was apparent. When the facts are examined, it is clear that, overall, women are now paying significantly less or will receive substantially more in paybacks from their policies than before the law took effect.

Our study was conducted by a University of Montana graduate student in economics, under the supervision of department professors. To identify rate changes due to factors unrelated to the non-gender law such as inflation, rates were also studied for Wyoming, a state similar in geography and population distribution but without a non-gender insurance law. Insurance companies doing the majority of business in Montana were surveyed on rates and benefits for women, men, and families before and after the law took effect. Data was collected on several age categories and policy variables (such as deductibles on health insurance). Commonly carried policies were studied, and all data received in response to our survey was used. The data was tabulated to provide a picture of the average rate and payback changes.

In addition to reporting our economic impact study's results, this information sheet includes background on the law and its implications.

WHAT IS THE PURPOSE OF THE GENDER-FREE INSURANCE LAW?

There are vital civil rights and economic reasons for Montana's gender-free law. These reasons led the Women's Lobbyist Fund—a coalition of 50 groups representing over 8,000 individuals--and over a dozen other state organizations to work for the law's passage in 1983 and to defend it from repeal in 1985 and 1987.

The economic grounds for the law are made clear by the rate changes described in this report, showing substantial financial gains for women since the law took effect.

The civil rights basis for the law is the Individual Dignity Clause of the

Montana Constitution, which specifically prohibits sex discrimination by private corporations as well as by government. When Chief Justice Jean Turnage was a state senator, he pointed out to the legislature the constitutional mandate for a non-gender insurance law:

> "When the state made vehicle liability insurance mandatory, it elevated such coverage to a civil right, and the Montana Constitution prohibits discrimination on the basis of sex against any person in the exercise of his civil rights."

Gender is an uncontrollable fact of birth. Sex discrimination in insurance is no different than discrimination in other areas such as employment or education, despite the fact that the industry hides behind actuarial tables in its attempt to justify this discrimination. Statistical differences exist just as clearly between men and women in education, housing, credit, and employment --categories which prohibit sex discrimination--as they do in insurance. No one disputes that there are statistical differences between men and women; the existence of such statistics is not enough to justify their use. Actuarial tables also show clear differences between races and members of religious groups, and race was used as a rate setting factor, until it became unacceptable to do so. Vietnam veterans show up in actuarial tables with a distinctly higher risk profile than other peers. All of these factors are socially unacceptable for rate setting.

There are strong grounds for prohibiting marital status discrimination as well. It is an outdated social stereotype to assume that being married equates with greater responsibility and lower risk. In auto insurance before the non-gender law was passed, a low rate was offered to the tiny percentage of young marrieds, with young singles having no way of obtaining the same low rate, even with flawless driving records. Furthermore, divorced people were frequently refused coverage or charged much higher rates by some companies, with unsubstantiated claims that divorced people were unstable and poor risks. Sex and marital status are illegal, unacceptable, and discriminatory ways of pooling risk. They prevent people from being properly rewarded for safe and healthy behaviors unless they happen to be of the gender or marital status deemed lower risk by the insurance industry.

SHOULDN'T PEOPLE BE RATED ACCORDING TO RISK?

The pooling of risk is fundamental to insurance rate setting, though marketing considerations actually have a greater influence on rates. There are many ways to pool risk, some more acceptable and accurate than others. Furthermore, gender was used in an arbitrary and inconsistent fashion for rate setting before the non-gender law was passed, contradicting the industry claim that rates were accurately cost-based.

One example is in auto insurance. Women of all ages have a significantly lower average accident rate than men, 30-40%. Even young women have a slightly lower accident rate than adult men. Under gender-based rates they were charged less than their male peers, but substantially more than adult men. Adult men and women were generally charged the same rate, though women received a 5-10% lower rate from a few companies. These rate-setting practices did not match the statistics.

Another example relates to the use of mortality data for setting rates and paybacks for life insurance and annuities. Industry data shows a 6-9 year difference between men's and women's lifespan, but only a 3 year difference was used for setting gender-based life insurance rates, minimizing the cost reduction to women. The full 6-9 year difference was used by the same companies for calculating monthly annuity payments, again minimizing the benefit to women. Futhermore, mortality tables can be misleading. 86% of women live no longer than men, and this large majority of women is discriminated against when they are assumed to have the long lifespan of a minority of women.

In health insurance, women were charged much more than men when rates were gender-based because the industry claims women are more expensive to insure due to higher hospitalization costs and more frequent doctors' visits. However, 1985 figures of the National Center for Health Statistics show men averaging longer hospital stays annually, 7.4 days compared to 6.3 for women including pregnancy, 7.0 excluding pregnancy. Furthermore, women are more likely than men to carry high-deductible policies that do not cover doctor's visits, minor problems, or brief hospital stays.

Gender and marital status are poor substitutes for factors with a more direct causal relationship to risk, such as mileage, sobriety, and obedience to traffic laws in the case of auto insurance. A study conducted by the National Insurance Consumer Organization for Congress showed a 98% correlation between the accident rates of men and women if miles driven were taken into account for young as well as adult drivers.

Safe, low-mileage young drivers--both married and single, male and female--could receive a low rate similar to that charged only to young marrieds before the law went into effect if insurance companies would base rates sufficiently on mileage and driving records. Companies use these factors to varying degrees, but insufficiently. It is to the advantage of companies as well as consumers for insurers to find ways to provide attractive rates to low-risk customers. Thus it is reasonable to assume that as the law remains in place, competition will lead to improved rating systems to reward these drivers.

In health and life insurance, factors such as smoking, drinking, weight, hazardous work, and medical history relate far more directly than gender to illness and mortality risk. Better use of these factors would improve policy affordability for healthy individuals.

HOW HAS THE GENDER-FREE LAW AFFECTED RATES?

Our study shows that the law's impact on insurance rates and paybacks generally has been beneficial. Two charts are attached showing lifetime impacts on women of gender-based and gender-free rates and benefits. The important economic impact of the non-gender law is vividly illustrated by these charts. A lifetime of auto, health, disability income, and whole life insurance and annuity coverage cost women $20,176 more than similarly situated men in higher premiums and lower paybacks. The lifetime gain to women on identical policies since the law took effect will be $21,859.

It is true that few women would carry all these types of insurance, but the economic gain to most women is clear.

HEALTH AND DISABILITY INCOME INSURANCE

Rate changes in these two categories are tremendously beneficial to women. The decrease in major medical insurance alone offsets increases experienced by women in any other category of insurance by several thousand dollars. Before the law was passed, Montana women were paying an average of $5,256 more than similarly situated men for 34 years of the same coverage, pregnancy excluded.

To assess the effects of the law, our survey on rate changes between April 1985 and April 1986 was sent to the top 50% of health insurers in Montana and Wyoming. The most recent list of the top companies available from the Montana Auditor's Office was 1984. It turned out that four of the companies were no longer writing individual policies in either state or no longer offering health insurance. Five of the seven active companies on the list responded.

Since the law went into effect, the survey showed over 84% of families, women, and men experiencing rate decreases in health insurance. Four main deductibles--$250, 500, 1000, and $2000--and three age categories--30, 45, and 60--were studied. This decrease is partially due to other market factors for some people, but Montana's rates dropped 3.26% more than Wyoming's during the same period, showing the law decreased most rates. The principal beneficiaries of rate decreases have been single women and couples, with and without children. For instance, single mothers with two children average a 16.6% annual decrease ($221.83) across all four deductibles.

In the common $500 deductible category, the following average annual premium changes were seen, with decreases in all but one category:

Policy holder	April '85	April '86	$ Change	% Change
AGE 30				
Single female	$ 712.19	$ 539.26	-$172.95	-24.28%
Single male	563.60	539.26	- 24.34	- 4.32
Family	1756.33	1513.25	- 243.08	-13.84
AGE 45				
Single female	$ 936.00	$ 782.87	-$153.13	-16.36%
Single male	725.03	782.87	57.84	7.98
Family	2191.25	1983.97	- 207.28	- 9.46
AGE 60				
Single female	$1217.40	$1195.21	-$ 22.19	- 1.82%
Single male	1251.96	1195.21	- 56.73	- 4.53
Couple	2410.72	2333.16	- 77.56	- 3.22

This generally beneficial impact on the affordability of health insurance is very important to Montanans, especially women. Only 37% of civilian workers in Montana are covered by employer health plans--the smallest percentage in the country. Less than half of these workers with employer health coverage are women, because Montana women are concentrated in lower paying jobs less likely to provide benefits. Montana women earn 53 cents for every dollar men earn, compared to 60 cents per dollar nationally. Affordable individual health insurance is needed by a majority of Montanans, especially low and moderate-income single women and single mothers. Nationally, slightly over 50% of

individual health policies are purchased by women. In 1984, 87,000 Montanans carried individual health insurance policies, according to the Health Insurance Association of America.

We have not yet surveyed companies on disability income insurance, but review of a major Montana insurer's typical policy with a 30-day waiting period showed women paying $7100 more for 34 years of coverage than a similarly situated man before the law went into effect. A woman carrying both health insurance and disability insurance would have paid $12,356 more than a man for the same coverage.

AUTOMOBILE INSURANCE

Our study looked at the eight insurers representing the top 56% of the market in Montana. Over 90% of Montana's drivers experienced no rate increase due to the law or received a decrease. Montana's 83.5% adult drivers (age 25 and older) already had rates that generally were gender-free.

Most Montanans received an increase due to factors unrelated to the law such as inflation and company loss ratios—an average of 5.4% for adult drivers and 10.23% for young drivers.

Rate changes for single men under 25 ranged from a semi-annual premium decrease of 20.4% to an increase of 3.2%, while young women saw increases ranging from 22.6 to 44.1%. Young marrieds experienced the greatest rate increase. Young married women drivers experienced increases ranging from 19.9% to 186.6%. Married men's rate changes ranged from a decrease of 14.1% to a 48.2% increase. It should be noted that women's percentages look larger because their rates were lower initially, so that their percentages are of a smaller dollar figure than men's percentages.

AVERAGE CHANGE IN MONTANA YOUTHFUL DRIVER SEMI-ANNUAL RATES

Driver Class	Male		Female	
	$ Change	% Change	$ Change	% Change
UNMARRIED PRINCIPAL				
Under 21	-$81.66	-17.34%	$104.70	39.14%
21-25	- 67.71	-21.06	51.46	25.98
UNMARRIED OCCASIONAL				
Under 21	-$30.94	- 9.77%	$54.71	24.74%
21-25	- 6.43	- 2.92	21.02	36.67
MARRIED PRINCIPAL				
Under 21	$100.80	29.50%	$222.00	150.00%
21-25	37.20	21.30	98.80	75.50
MARRIED OCCASIONAL				
Under 21	-$39.38	- 5.63%	$119.55	82.80%
21-25	- 10.47	- 2.92	51.15	3.74

Some of these increases are dramatic, but it must be taken into account that young married drivers are less than 3.5% of the driving population. Furthermore, suggestions are made earlier in this report on ways companies could provide more desirable rates to safe young drivers regardless of gender or marital status. The increases seen by young single women and young marrieds are not the fault of the law, but rather of the unfortunate way insurers handled the adjustment to gender-free rates. It also appears that some insurers may have indulged in illegal political ratemaking, raising rates excessively to negatively influence public opinion of the law. A formal complaint has been filed with the Montana Insurance Department.

Four other state--Hawaii, Michigan, North Carolina, and Massachusetts--have eliminated gender and marital status for auto insurance rate setting. None of them experienced the magnitude of rate increases passed on to many young Montana drivers. This difference was due in part to innovative approaches such as safe driver rebates and expanding the adult driver category to include 23 and 24-year-olds.

Even for Montana young marrieds, there is a wide variation in rates, clearly indicating that companies implemented the law in drastically different ways. Identical policies for young drivers vary by more than $300 annually, depending on the company, and young marrieds can find policies only slightly more expensive than before by shopping around.

TERM LIFE INSURANCE

Ten out of 12 life insurance companies doing at least $1 million of business annually in Montana answered our survey on term policies with face amounts of $50,000 and $100,000 sold to 35-year-olds. Because one company had extremely atypical high rates, the average (mean) did not accurately reflect changes resulting from the non-gender law. Instead, the median method of calculating the central tendency was used. At the median, men's rates dropped and women's rose slightly. By the tenth year both men's and women's policies will be a better value in Montana than Wyoming. Also, with an annual increase of only $9.00 on a $50,000 policy, term insurance is no less affordable to women than before.

	Gender-based		Current	% Median Change		$ Change	
$50,000 Term	Men	Women	Current	Men	Women	Men	Women
Premium Yr. 1	$ 94.00	$ 83.00	$ 92.00	-2.13%	10.80%	-$2.00	+$ 9.00
Premium Yr. 10	162.50	146.00	155.00	-4.60	6.26	- 7.50	+ 9.00

$100,000 Term	Men	Women	Current	Men	Women	Men	Women
Premium Yr. 1	152.00	134.00	151.00	- .50	12.87	-$1.00	+$17.00
Premium Yr. 10	341.00	276.00	290.00	-14.74	5.34	-51.00	+$14.00

WHOLE LIFE INSURANCE

The same companies were surveyed for term and whole life. Over a lifetime a woman's $100,000 whole life policy was an average $2,543 poorer value than a man's before the law took effect. The same policy purchased since the law took effect will be worth $7,457 more to a woman. Premiums, dividends, and cash values all rose on $50,000 and $100,000 face-value policies purchased by men

and women at age 35. Women experienced greater increases in premiums, dividend accumulation, and cash values than men when gender was eliminated as a rating factor. All were lower under the gender-based system. For a $50,000 policy, women's average annual premiums rose 8.33%, their dividends increased 13.7%, and their cash value rose 8.81%. Men's premiums rose .67%, dividends rose 7.7%, and their cash value rose 8%.

Whole life premiums also increased in Wyoming for men and women, indicating that part of Montana's rate increase in whole life is due to factors other than the non-gender law. Also, it should be noted that when premium payments, dividends, and cash values are taken into account, Montana policies are on the average better values than the same policies in Wyoming, for women as well as men. This contradicts the claim made by some insurers that many Montanans are finding better buys by purchasing policies in Wyoming. To determine the true worth of a policy, cash values and dividends must be considered as well as premiums.

time value of money

and time value of money

ANNUITIES

Equalization of men's and women's monthly annuity payments has benefited women significantly. Before the non-gender law, women and men paid the same annuity premiums, but women received much less in monthly payments. Women were forced to live on less per month than men and the majority of women who did not live longer than men were discriminated against. Our study showed that over a 10-year period, a woman with a gender-based annuity would receive $6,720 less than a man. The same annuity obtained since the law took effect will be worth $5,880 more to a woman.

We studied $100,000 whole life policies converted to annuities. Due to the non-gender law, women will receive $49 more a month for 10-year certain annuities, and men will receive $7 less a month. For 20-year annuities, women will receive $32 more a month, and men will receive $12 more a month. These figures show a clear gain to three out of four groups studied.

WHAT HAS THE IMPACT BEEN ON INSURANCE BUSINESSES?

According to Montana's Insurance Commissioner Andrea Bennett, 58 insurance companies have been newly licensed in Montana since the law took effect, compared to 8 who ceased doing business or dropped product lines. Though some product lines have been dropped, when one examines our rate study results and the rate survey completed by the Insurance Commissioner's Office, it is clear that a tremendous range of products and prices is currently available to Montana consumers. Also, some of the health insurance companies we surveyed reported a significant increase in policies sold since the law went into effect, another indicator of the market's vigor.

WHY HAS THERE BEEN OPPOSITION TO THE LAW?

There has been a huge amount of misinformation circulated about the law. For instance, at least one-third of Montana's drivers received misleading or dishonest premium inserts from their insurance companies, using the law as a scapegoat for often unrelated rate increases. In addition, many insurance agents verbally blame the law for increases. Consumers have naturally tended to believe what their companies have told them.

The gender-free law has been blamed for just about everything except changes in the weather! One over-30 male legislator was told by his auto insurance company that his rates went up because of the law. Another legislator was told by an agent that his farm liability rates had gone up because of the law. One company blamed the law for a homeowners policy increase, never gender-based. An unsuccessful candidate for the legislature ran her campaign using the claim that the non-gender law was at fault for the problems of the workers compensation system. The law had nothing to do with any of these developments, but such misstatements have been typical.

Furthermore, people are much more likely to complain about rate increases than price decreases, especially since companies have rarely given credit to the law for decreases it has caused.

Our organization has conducted over 30 public information meetings since the non-gender law went into effect. We have found that with only a few exceptions, when people were given an opportunity to examine the facts about the law, they changed from opponents to supporters. This has included parents of young single women and young marrieds, who had not had the chance of seeing the big picture of decreases and increases and lifetime benefits.

SUMMARY

Due to the gender-free law, some rates went down and others went up for both men and women. There was a wide range of price changes for all products, and consumers should be encouraged to shop around for the best values. Overall, the law has resulted in significant public benefit for women, families, and men. Over a lifetime, women will gain as much as $22,000 in premium savings and improved policy paybacks.

The non-gender insurance law promotes greater fairness in rate making and is the only alternative consistent with the Montana Constitution. By eliminating the discriminatory rating factors of gender and marital status, the law sets the stage for future use of more appropriate rating factors. This development would result in a substantial rate reduction for most of the young single women and young marrieds who have experienced the greatest increases due to the way auto insurance companies restructured their rates. In the future, life insurance may become an even better value for women when companies follow a more precise rate adjustment process. The positive impacts of the law already far outweigh its negative impacts on some rates. When the law and the market are given more time to work, we are confident that further benefits will emerge.

For more information about the activities of our Non-Gender Insurance Project, including technical assistance to other groups; copies of our complete Montana economic impact studies; consumer buying guides for automobile, health, and disability income insurance; or information about the efforts of other state and national groups to eliminate gender discrimination in insurance and annuities, please contact Project Director Marcia Youngman at the address listed on the first page of this fact sheet.

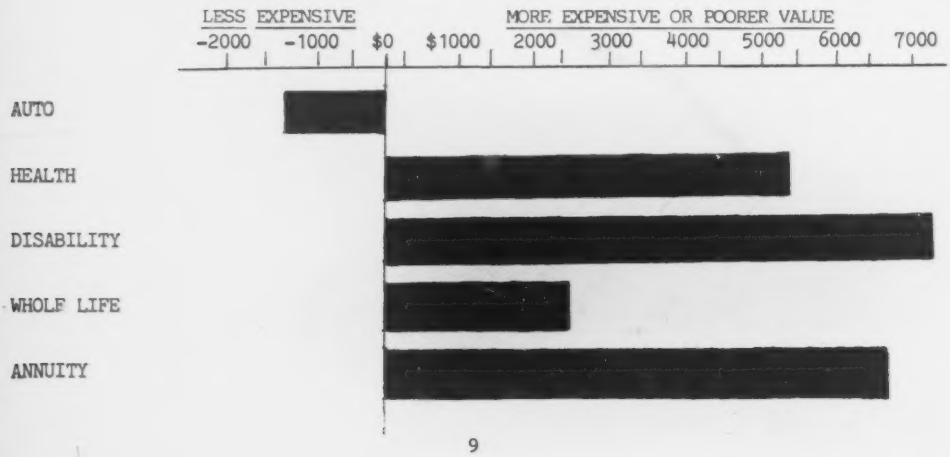
LIFETIME COST TO WOMEN OF SEX DISCRIMINATORY INSURANCE RATES AND BENEFITS

Prepared by the Non-Gender Insurance Project of the Women's Lobbyist Fund, 1214 W Koch, Bozeman, Montana 59715 (406) 587-5704; Marcia Youngman, director

Before Montana's non-gender insurance law took effect in October 1985, women paid more or received less in paybacks than similarly situated men for every type of insurance listed below except auto insurance for young drivers. In 1986, a study was conducted for our organization on insurance policy rates and benefits before and after the law went into effect. Data was collected from the insurance companies doing the majority of business in Montana on actual commonly carried policies.

The lifetime impact figures below were calculated after tabulating the data on all comparable policies to determine average costs and benefits. No data received in response to our survey was excluded, so the results are neither slanted nor extreme. The economic impact on women of sex-discriminatory coverage was severe. Women paid (and received in paybacks) the following average amounts:

$ - 1,443	less than men for auto insurance for the typical 9-year gender-based period, ages 16-25
+ 5,256	more for 34 years of major medical insurance, $500 deductible
+ 7,100	more for 34 years of disability income insurance
+ 2,543	$100,000 whole life provided this poorer value (counting premiums, dividends, and cash values); $50,000 came out at +$1,297
+ 6,720	received this much less from a 10-year certain annuity converted from the whole life policy
$ + 20,176	A lifetime of auto, health, disability income, and whole life insurance and annuity coverage cost women this much more than men in higher premiums and lower paybacks.

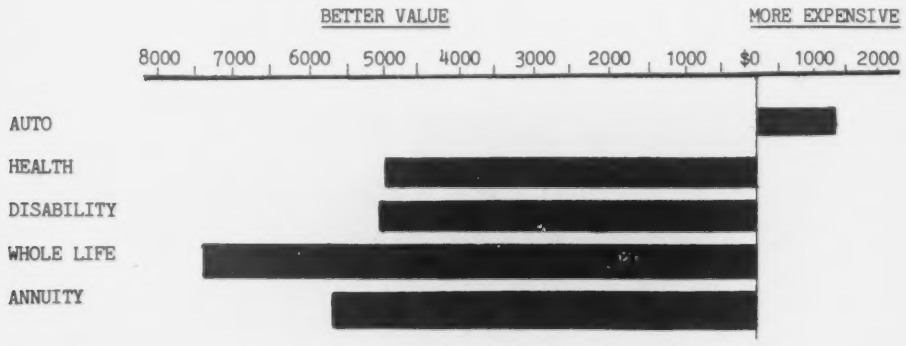


LIFETIME BENEFICIAL IMPACTS OF THE MONTANA NON-GENDER INSURANCE LAW ON WOMEN

The following are lifetime average costs or savings to women for policies sold since the non-gender insurance law took effect October 1, 1985. The data base is the same economic impacts study used to prepare the chart on lifetime impacts of sex discrimination. Information was collected from the insurance companies doing the majority of business in Montana on commonly carried, moderate-size policies.

Women benefit substantially in every category of insurance shown below except for auto insurance for young drivers. Most companies passed on rate increases unrelated to the law at the time it took effect (for inflation, company loss experience, etc.), or the law's positive financial impact on women represented by these figures would show as even greater. Also, some companies used a poor rate adjustment process in combining men's and women's rates, and some auto insurers even may have raised rates excessively to negatively influence public opinion. Despite all this, the following figures show tremendous economic gains for women (underlined numbers represent savings in premiums or better value policies considering both premiums and paybacks):

$ 1,458	auto insurance will cost young women this much more for the 9-year period under 25
4,980	major medical, $500 deductible, will cost this much less for 34 years coverage
5,000+	disability income insurance will cost at least this much less, possibly averaging as high as $7,000; (data not yet as complete as it is for other categories)
7,457	whole life, $100,000 policy, will be worth this much more counting premiums, dividends, and cash values
5,880	annuities will provide this much more in paybacks on a 10-year certain policy; ($7,680 for a 20-year certain policy)
$21,859	Women will gain at least this much over a lifetime in lower premiums and/or higher paybacks.



MONTANA'S GENDER-FREE INSURANCE LAW

49-2-309. Discrimination in insurance and retirement plans. (1) It is an unlawful discriminatory practice for any financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits.

(2) This section does not apply to any insurance policy, plan, coverage, or any pension or retirement plan, program, or coverage in effect prior to October 1, 1985.

History: En. Secs. 1, 3, Ch. 531, L. 1983.

26-996 (216)